F31/5

FEDERAL INTERAGENCY MEDICAL RESOURCES SHARING AND COORDINATION ACT OF 1980

HEARING

BEFORE THE

COMMITTEE ON GOVERNMENTAL AFFAIRS UNITED STATES SENATE

NINETY-SIXTH CONGRESS

SECOND SESSION

ON

S. 2958

TO INSURE THE DEVELOPMENT AND IMPLEMENTATION OF POLICIES AND PROCEDURES TO ENCOURAGE THE VETERANS' ADMINISTRATION AND THE DEPARTMENT OF DEFENSE TO COOPERATE IN THE EFFICIENT AND EFFECTIVE USE OF FEDERAL MEDICAL RESOURCES, AND FOR OTHER PURPOSES

JULY 30, 1980

Printed for the use of the Committee on Governmental Affairs

NEWARK PUBLIC LIBRARY

DEC 16 1980

U. S. GOVT. PUBS.
DEPOSITORY 376

U.S. GOVERNMENT PRINTING OFFICE
67-070 O WASHINGTON : 1980

Y4.G74/9:

COMMITTEE ON GOVERNMENTAL AFFAIRS

ABRAHAM RIBICOFF, Connecticut, *Chairman*

HENRY M. JACKSON, Washington
THOMAS F. EAGLETON, Missouri
LAWTON CHILES, Florida
SAM NUNN, Georgia
JOHN GLENN, Ohio
JIM SASSER, Tennessee
DAVID PRYOR, Arkansas
CARL LEVIN, Michigan

CHARLES H. PERCY, Illinois
JACOB K. JAVITS, New York
WILLIAM V. ROTH, Jr., Delaware
TED STEVENS, Alaska
CHARLES McC. MATHIAS, Jr., Maryland
JOHN C. DANFORTH, Missouri
WILLIAM S. COHEN, Maine
DAVID DURENBERGER, Minnesota

RICHARD A. WEGMAN, *Chief Counsel and Staff Director*
MARILYN A. HARRIS, *Executive Administrator and Professional Staff Member*
HANNAH S. SISTARE, *Chief Minority Counsel and Staff Director*
ELIZABETH A. PREAST, *Chief Clerk*

best copy available

CONTENTS

Page

Opening statement: Senator Percy 1

WITNESSES

WEDNESDAY, JULY 30, 1980

Gregory J. Ahart, Director, Human Resources Division, U.S. General Accounting Office, accompanied by David P. Baine, Group Director, and Fred E. Yohey, Jr., Management Analyst, Human Resources Division, and Darryl W. Dutton, Management Analyst, Los Angeles Regional Office 5

Admiral J. William Cox, commanding officer, Naval Regional Medical Center, San Diego, Calif 51

F. Todd Yates, Chief, Supply Service, Veterans Administration Medical Center, San Diego, Calif 52

General Quinn H. Becker, M.C., Superintendent, U.S. Army Academy of Health Sciences, Department of the Army 56

John Moxley III, M.D., Assistant Secretary of Defense for Health Affairs, accompanied by Admiral W. P. Arentzen, surgeon general, U.S. Navy; General Charles C. Pixley, surgeon general, U.S. Army; and General Paul W. Myers, surgeon general, U.S. Air Force 59

Donald L. Custis, M.D., chief medical director, Department of Medicine and Surgery, Veterans Administration, accompanied by William Jacoby, M.D., deputy chief medical director, and Robert Coy, deputy general counsel 83

Alphabetical list of witnesses:

Ahart, Gregory J.:
  Testimony 5
  Prepared statement 11
  Responses to written questions from Senator Percy 66
Arentzen, W. P.: Testimony 59
Baine, David P.: Testimony 5
Becker, Quinn H.: Testimony 56
Cox, J. William: Testimony 51
Coy, Robert: Testimony 83
Custis, Donald L.:
  Testimony 83
  Prepared statement 90
  Responses to written questions from Senator Percy 96
  Additional material 99
Dutton, Darryl W.: Testimony 5
Jacoby, William: Testimony 83
Moxley, John, III:
  Testimony 59
  Responses to written questions from Senator Percy 76
Myers, Paul W.:
  Testimony 59
  Prepared statement 71
Pixley, Charles C.:
  Testimony 59
  Prepared statement 68
Yates, F. Todd: Testimony 52
Yohey, Fred E., Jr.: Testimony 5

Additional material submitted for the record:

Page
Text of S. 2958 101
GAO report entitled, "Legislation Needed to Encourage Better Use of Federal Medical Resources and Remove Obstacles to Interagency Sharing," June 14, 1978 109
Letter to Senator Ribicoff from James M. Frey, Assistant Director for Legislative Reference, OMB, August 19, 1980 280
Letters to Senator Percy from:
  Richard M. Ryan, Jr., associate dean, Harvard Medical School, July 21, 1980 281
  John F. Heilman, national legislative director, Disabled American Veterans, July 15, and August 15, 1980 283
  George A. Conn, national legislative director, Paralyzed Veterans of America, with enclosure, August 15, 1980 288
  R. E. Lyngh, director, National Veterans Affairs and Rehabilitation Commission, The American Legion, July 16, and Aug. 7, 1980 297
  Gabriel P. Brinsky, national service and legislative director, AMVETS, July 28, 1980 302
  Marshall A. Falk, M.D., dean, University of Health Sciences, The Chicago Medical School, with enclosure, July 9, 1980 303
  John E. Byfield, M.D., Ph.D., professor of radiology and medicine, chief, Radiation Oncology, University of California, San Diego, August 1, 1980 308
Letter to Alan Mertz, professional staff member, U.S. Senate, Committee on Governmental Affairs, from C. Alex Alexander, M.D., Dr. P.H., June 30, 1980 310
Memo from Carlton M. Smith, medical center director, Veterans Administration, with enclosures, Sept. 13, 1980 312
"Military, VA Hospitals Found Not Sharing Costs," The Washington Post, July 29, 1980 321
"Legislation Pending To Mandate Cross-Agency Use of Equipment," from U.S. Medicine—Sharing report 322
Letter to Senator Ribicoff from Patricia Roberts Harris, Secretary, Department of Health and Human Services, September 10, 1980 324

READEX
FICHE

FEDERAL INTERAGENCY MEDICAL RESOURCES SHARING AND COORDINATION ACT OF 1980

WEDNESDAY, JULY 30, 1980

U.S. SENATE,
COMMITTEE ON GOVERNMENTAL AFFAIRS,
Washington, D.C.

The committee met at 9:04 a.m., in room 3302, Dirksen Senate Office Building, Hon. Charles H. Percy presiding.

Present: Senator Percy.

OPENING STATEMENT OF SENATOR PERCY

Senator PERCY. The Governmental Affairs Committee will come to order, 4 minutes late. I apologize to our witnesses. We generally like to start on time. We couldn't have a better reason this morning. The Senators' prayer breakfast did not adjourn until 9:00. Because some of our witnesses cannot stay for the entire hearing, I am going to summarize some of the findings of our own committee, and some of the conclusions we have come to. Ordinarily when we start a hearing, we are supposed to open possibly with a totally open mind. In this case, we have done enough preliminary investigation to determine the nature of the problem, the potential of the opportunity we face ahead of us, the barriers that exist for agencies that would like to operate more efficiently and effectively and introduce legislation so that our witnesses can address themselves to a specific piece of legislation, but by all means we want to emphasize that is not set in concrete at all. That it is totally open to amendment, modificiation, improvement, and refinement by all of our witnesses and we will value very much, indeed, your input.

The committee will hear testimony this morning that the Veterans Administration and Defense Department have failed, primarily due to conflicting laws and regulations, to share some of the billions of dollars worth of their medical resources, thus wasting millions of dollars and losing opportunities to improve care for patients. S. 2958, which I introduced with Senator Proxmire, as a principal Democrat and cosponsor, is designed to help end these inefficiencies. My staff has uncovered examples of waste and inefficiency in the Federal Government's $10 billion a year direct health care system in Chicago and Boston.

In North Chicago, the U.S. Navy, at Great Lakes, spends $25 million a year to operate a modern, air-conditioned, and nearly empty hospital. An average of only 120 of its 700 beds are filled at any given time. Only two-thirds of a mile away sits a Veterans Administration hospital, also a Federal facility, that is planning to spend $25 million in coming years to renovate its own facilities, made up largely of inefficient 1905–40 era buildings. Currently, VA patients are not allowed to use the empty Navy beds.

A critical shortage of Navy doctors at Great Lakes is forcing the military to spend over $1 million a year to hire contracted doctors, and almost $2 million a year to send patients out to the private sector for care, where costs are three to four times higher than military care. Meanwhile, the VA facility next door enjoys a relative abundance of doctors through its affiliation with a local medical school. Many Navy patients cannot be treated by VA doctors.

In a meeting with committee staff, local VA and Navy officials eagerly described how a sharing agreement between these two Federal agencies is desirable. Sharing would reduce the need for many of the renovations at the VA hospital, save administrative costs by combining duplicated support services, and reduce the cost to the Federal Government and beneficiaries by bringing Navy patients now sent to private hospitals back under Navy care.

This opportunity for saving money and improving care has failed to get off the ground for many of the same reasons that attempts to share have run amuck in dozens of other areas—conflicting Defense Department and Veterans Administration laws and regulations, a lack of incentives at the local level, and the absence of VA-DOD guidance needed to implement sharing and coordination.

The Federal Government's attempt at cross-agency planning and coordination are so haphazard that this opportunity in Chicago, according to Navy officials, may have gone completely unnoticed had it not been for the fact that a Navy and VA official from Washington happened to be seated next to one another on a plane and began discussing the problems at their respective facilities and the possibilities for sharing. Movement toward working out a sharing arrangement which began almost a year ago has stalled.

In Boston, where an agreement between the VA and the Army to share orthopedic services that could have saved the Federal Government hundreds of thousands of dollars was rejected by the Army Comptroller. The agreement fell through because, among other things, the two agencies could not agree on whether to call their proposal a "contract" or a "sharing agreement." Because of the impasse, the Army is flying dozens of its patients fron Boston to Walter Reed Hospital in Washington on its very expensive air evacuation system when they could be treated at less cost and more conveniently at the Boston VA.

The GAO has also uncovered many similar cases, including one at Federal facilities in San Diego. San Diego Navy and Veterans Administration officials will testify this morning how their plan to share an expensive Argon Laser fell through for many of the same reasons that well-intentioned attempts to save the taxpayers' money and provide better patient care have failed elsewhere.

We will also learn how the Navy's $293 million hospital in San Diego has been planned without any coordination with the Veterans Administration hospital nearby, which could benefit from sharing. For example, there are no formal plans for the VA to be provided any radiation therapy services, for which they are currently spending $230,000 a year outside the Federal sector, in the currently sponsored construction.

The Federal Government spends $10 billion annually to provide direct health care to its beneficiaries. The Veterans Administration, with 171 hospitals, and the Department of Defense, with 129 hospitals, make up by far the bulk of the Federal system. In many areas where one agency maintains a hospital, the other agency has a similar facility or has beneficiaries entitled to Federal health care. In spite of this, the amount of sharing between the two is very limited.

The seriousness of the situation is brought home by the following example:

One requirement of Public Law 89-785, which permits some sharing by VA, is that the VA is to annually report on its sharing activities. The latest report—for fiscal year 1979—submitted by the VA, is sobering. It indicates that the amount of sharing taking place between the VA and the Defense Department is almost nonexistent under this authority.

Overall, the VA, in fiscal year 1979, entered into 240 sharing agreements with various health care providers. These agreements resulted in about $20.1 million of services being exchanged. However, only 4 of the 240 sharing agreements were with DOD facilities. And, almost unbelievably, only $17,000 of the $20.1 million of services exchanged were services provided by the VA facilities to DOD beneficiaries. Therefore, the extent of interagency sharing between the VA and the Defense Department under this authority amounts to less than one-tenth of 1-percent of the total value of services shared by VA. Other authorities under which VA and DOD may share have enabled only limited sharing—they have proved to be far too restrictive to allow millions worth of cross-agency coordination to be implemented. Obviously something is wrong.

Similar cases of underutilization and duplication in the private sector, along with spiraling health care costs, prompted the Congress to enact legislation in 1974 mandating non-Federal hospitals to coordinate and plan the use of their medical resources. Although Federal agencies were included in the advisory bodies planning private-sector coordination, no sharing between the Veterans Administration and Department of Defense was required, in spite of the fact that they comprise two of the large medical systems in the United States.

In response to the 1974 act, tightening Federal budgets, and the impact of inflation on medical costs, the Congress, the GAO, and the agencies began to look at opportunities for sharing and coordination at the Federal level.

After over 5 years of study and 16 reports, the GAO has concluded that while the Veterans Administration and Department of Defense have different missions, there remain scores of opportunities for sharing and coordination that could potentially save hundreds of millions of dollars and improve the health care being provided.

They also found that legislation would be required to clear the legal and administrative obstacles to interagency sharing. Incredibly, until today, 2½ years after the GAO originally made its recommendations, not one congressional committee has asked the GAO to testify to its report.

The Federal agencies responded somewhat cautiously to GAO's report by forming an interagency committee. We will hear today that the committee's findings confirm what GAO found—legislation is needed.

The bill I have introduced is based largely on the findings and recommendations of the GAO, the Federal agencies, and the interagency committee. This legislation will serve to eliminate the legal obstacles to more comprehensive sharing. It will express, for the first time, a mandate addressing the need for assessing the opportunities for sharing existing resources and planning for future development.

The bill is not designed to dictate sharing arrangements—that would be an ineffective approach. Instead, it provides incentives and flexibility at the hospital director level, such as allowing them to be reimbursed directly by another Federal facility for shared services, thereby encouraging money saving sharing among Federal facilities.

In the weeks preceding this hearing, the committee has received calls and letters from Federal hospital administrators across the country, like those here today, who are enthusiastically supporting the legislation that will untie the bureaucratic knot strangling their efforts to share with other Federal agencies.

In many cases, like San Diego, hospital administrators trying to share expensive equipment to save money have given up their attempts in the face of bureaucratic road blocks, strangling laws and redtape.

It would be unfair to characterize sharing the Federal sector as a total failure.

In spite of legal administrative barriers, some progress has been made. As we will hear, sharing within each agency, particularly between the military services has been very successful. Sharing between Federal agencies, however, clearly holds the greatest potential for cost savings, but Congress must do its part before this can happen.

I know we all go back to our personal experiences in some of these situations. The solution of this problem depends upon two remedies. First, the legislative remedy, to remove the barriers that actually do exist—there are hurdles that have to be overcome and can only be overcome by the Congress.

The second is attitude. I found both barriers in World War II right in the midst of the war, as a procurement officer for Naval Ordnance. I found there was a lack of sharing in the midst of the war when in the Navy, Army, and Air Corps there was a reluctance to share equipment right in the middle of the war—"it was our equipment, by gosh, let them get theirs; it is ours." There is that attitude. That is one reason the Department of Defense was created, to pull everything together to cause more sharing. That is why we have to have not only the legislative base but an attitudinal change.

The taxpayers of this country expect that we use our facilities most effectively and most efficiently, just as they are used in the private sector, in the conglomerate. You find someone at the top has to pull things together. We have the job, all of us in this room, to pull things together so we are not wasteful within the Federal

Government. I think the taxpayers are looking to us to find ways to run our operations much more effectively and efficiently.

The case I have given right in my own home State just is ludicrous, ludicrous from the standpoint of wasted money, wasted facilities and lack of services being offered to people who are deserving of that service.

So it is in that spirit that I welcome very much indeed our witnesses today and for the thought they put into this testimony.

Our first witness will be Mr. Gregory Ahart, Director, Human Resources Division, General Accounting Office. I wonder, Mr. Ahart, would you introduce your colleagues that are with you today?

TESTIMONY OF GREGORY J. AHART, DIRECTOR, HUMAN RESOURCES DIVISION, U.S. GENERAL ACCOUNTING OFFICE, ACCOMPANIED BY DAVID P. BAINE, GROUP DIRECTOR, HUMAN RESOURCES DIVISION; FRED E. YOHEY, JR., MANAGEMENT ANALYST, HUMAN RESOURCES DIVISION; AND DARRYL W. DUTTON, MANAGEMENT ANALYST, LOS ANGELES REGIONAL OFFICE

Mr. **Ahart**. I will be happy to, Mr. Chairman. On my left is David Baine, Group Director in the Human Resources Division who has had responsibility for our work in this area. To my far right is Fred Yohey of Mr. Baine's staff and on my immediate right is Darryl Dutton from the Los Angeles Regional Office who also has participated heavily in our work in this particular area.

Senator **Percy**. We welcome you very much. Once again I would like to say GAO is an invaluable service, arm of the Congress. We simply could not do our work without the objective and thorough study that you give to these problems. If ever there is a cost-effective operation in the Federal Government, this is it. You give back to the taxpayer your own operating expenses 100-fold a year.

So we are very grateful indeed for the work you have done not only in this one case but the many, many cases in the 14 years I worked intimately with you. Thank you very much. Go right ahead. You can summarize your testimony any way you wish. The full effect will be incorporated in the record.

Mr. **Ahart**. I do have a rather lengthy statement I would like to file for the record. I know you are short on time. You said quite a bit about the subject in your opening statement. I would like to be as brief as possible and go right to the questions. As you mentioned, we have spent a lot of time over the past several years in looking at the problem of interagency sharing. We are pleased to be here today to comment on S. 2958, a bill which you introduced to help encourage Federal agencies to share medical resources on an interagency bases. In our opinion, this bill constitutes a legislative statement of policy and guidance which is very much needed. It addresses the obstacles to interagency sharing of medical resources indentified in our June 1978 report, "Legislation Needed to Encourage Better Use of Federal Medical Resources and Remove Obstacles to Interagency Sharing."[1]

We believe that increased sharing would benefit the Federal Government by providing opportunities for:

---

[1] See p. 109.

First, eliminating or consolidating underused or duplicative facilities, equipment and staff.

Second, reducing the Government's reliance on health delivery programs which provide care not available from the DOD, VA, and the Public Health Service.

And finally, increasing staff proficiency and improving patient care by consolidating workloads and resources.

Also, beneficiaries night be able to be treated in Federal facilities closer to their residences and might themselves save money because they would not be required to pay specified portions of the cost of care, as they would have to do under CHAMPUS, for example.

We believe the situation has changed very little since our June 1978 report was issued as to sharing medical resources in the Federal sector. Our report contains numerous examples of where opportunities exist for sharing among various agencies.

Until recently, each Federal agency planned its health delivery system in terms of having sufficient services for the beneficiaries for which that agency was responsible without considering the needs and capabilities of other Federal agencies.

However, in early 1978, while our work on our report was going on, the principal medical officials of DOD, VA, and the Department of Health and Human Services agreed that one approach to providing the highest quality care with greatest efficiency was to accept common goals and share resources. A committee called the Federal Health Resources Sharing Committee was established to improve the overall quality of health care and reduce the excess consumption of scarce resources through coordinated planning arrangements.

To accomplish its goals and objectives, the Sharing Committee has used several legislative authorities which permit Federal interagency sharing, but which do not give the Legislative guidance needed to implement a full and effective medical resources sharing program. We believe that S. 2958 would provide such guidance for the VA and DOD, and pave the way to substantially increased sharing of Federal medical resources.

The basic reasons for the lack of substantive progress in taking advantage of the sharing opportunities were identified in our June 1978 report. In most instances, these were the absence of a specific legislative policy for sharing and the resulting lack of adequate headquarters guidance on how to share; restrictive agency regulations, policies and procedures; and inconsistent and unequal reimbursement methods.

We believe Federal agencies attempts to share, whether initiated at the local Federal hospital level or by an interagency group such as the Federal Health Resources Sharing Committee are hindered by the same types of obstacles.

We strongly believe that the legislative and administrative obstacles could be eliminated without adversely affecting the level of quality of care given to beneficiaries.

Many of S. 2958's provisions would carry out the intent of the legislative proposal presented in our June 1978 report and are, in our opinion, important and necessary to accomplishing the bill's purpose.

Before addressing the specific sections of the bill, I would like to suggest the Committee include in the bill the Department of Health and Human Services. As you mentioned and we recognize, DOD and VA represent the majority of the Federal Government's direct health care resources. Nevertheless, the Department of Health and Human Services, through its Public Health and Indian Health Services, provides care to a substantial Federal beneficiary population. We believe the inclusion of the Department in the bill will further enhance your proposal for an effective interagency medical resources sharing program.

Specifically, with respect to the bill, we would just like to emphasize some points.

Section 2 recognizes the importance of both VA's and DOD's current responsibilities and their respective missions. This is important to the agencies and we believe the agencies' implementation of this legislation would enhance the ability of each agency to seek and obtain alternative sources of care for their beneficiaries while controlling rising health care costs.

Section 2 also states that the purpose of the act is to clarify and expand the authority of VA and DOD as direct health care providers in order to facilitate Federal interagency sharing of medical care and medical care support resources. This is important because the resources to be shared would not be limited to only direct medical services but would, and should, include the ancillary support services needed by Federal direct health care providers.

Section 3 of the bill defines negotiated costs as the cost of services provided between Federal facilities as determined by local hospital officials on a medical service-by-service, hospital-by-hospital basis in an equitable and consistent manner.

We believe a negotiated cost rather than other types of cost specified in existing sharing legislation is needed if an effective sharing program is to be implemented. Any reimbursement mechanism adopted by the agencies should be flexible enough to encourage and permit negotiations between local Federal hospital officials to determine acceptable rates of reimbursement for services shared. It is necessary that the reimbursements be mutually agreeable to both parties for sharing to really take place.

Also as provided in section 4, the reimbursement would be credited to the specific facility which provided the medical service. Without such a provision, the incentive at the local Federal hospital level to share is diminished or lost.

Section 4 of the bill would also establish a Federal Interagency Health Resources Committee. We had recommended in our report that responsibilities similar to those contained in section 4, be assumed by the Office of Management and Budget. However, OMB has consistently taken the position that the more formal oversight and coordination we recommended was not necessary. It preferred to rely on its budget examiners and other staff already working with the affected agencies.

The bill clearly delineates congressional policy on the issue of medical resources sharing and specifies that the Federal Interagency Health Resources Committee's primary responsibility is to fully and effectively implement this congressional policy. We believe this satisfies the intent of our report recommendation.

Finally, section 4 permits the agencies to request from the Congress relief from personnel ceilings and other restrictions as well as funding needed to treat other agencies' beneficiaries. Such requests must be substantiated by the providing agency. We endorse these provisions.

In summary, Mr. Chairman, we believe the Federal Government has the opportunity to serve as a model for effective health resources planning and use. In our opinion, the Congress enactment of S. 2958 would represent a significant step in that direction by creating an environment in which Federal agencies could make the most cost-effective use of their medical resources while maintaining or perhaps enhancing the quality of care provided to the respective beneficiaries. That briefly summarizes my statement, Mr. Chairman. We would be pleased to respond to any questions you may have.

Senator PERCY. Thank you very much, indeed, Mr. Ahart. We will have some questions to submit for the record after we have had a chance to more carefully study your excellent testimony. Just a few now to move our hearings along, because we have a problem today on legislation that I am working on on the floor also. I don't want to delay our proceedings, so we will try to move it as rapidly as we can so we get it all done by 11:30 or so. One of the principal thrusts of your work appears to be a substantial savings to the Federal Government if effective agency sharing were to be implemented today, for instance, in peacetime. Do you have any idea how much money could be saved? What is the potential for saving today?

Mr. AHART. We don't have any precise number that we could give the committee, Mr. Chairman. We have testified before that just because of the magnitude of the Federal direct health care delivery system that you spelled out in your opening statement, of $10 billion, if you could save only 1 percent of that, you are talking about $100 million annually. The precise amount that could be saved will be very difficult to deternine even when S. 2958 is fully implemented.

There is reported to be a substantial amount of sharing going on now, as you know. We think that can be enhanced considerably. Preliminary data obtained by the current Sharing Committee indicates interagency sharing amounting to about $50 million a year. Other than this preliminary data I don't think we can get very precise. If construction medical facilities themselves can be avoided or as you mentioned in the north Chicago situation, major renovation can be avoided by a sharing agreement, the Government would obviously save a lot of front-end cost.

Every Federal direct health facility has to be staffed and you have to have expertise to run it. Anytime you can avoid putting in a piece of specialized medical diagnostic equipment which in turn has to have its own specialists and technicians to run it, again you save not only the front-end cost of gettinq that equipment but the longer-term cost of staffing it with technicians.

So I think we are talking about a sizable amount of money and one worthwhile to pursue, but I would not venture to say with any degree of precision what that potential is in dollar terms.

Senator **Percy**. I would just think, looking at the size of it, at the potential that we have seen—and I haven't consulted with my staff—but I put a goal to try and achieve 2½ percent savings, around $250,000,000. I think that is an achievable goal. After this legislation is enacted, we will try to figure out some way that we can all work toward such a goal. I think a saving like that would really be significant and once you see the potential saving, then you can even go beyond that.

Is it not true in addition to saving money, however, you can actually provide better service many times to the people who are eligible and warrant that service, deserving of it, you can offer better service by sharing facilities?

Mr. **Ahart**. I think that is certainly true and our report brought out some examples of that. One that comes quickly to mind, dealt with a patient with a spinal cord injury. It is very important that such a person be handled in a facility which meets the urgent needs of taking care of that kind of problem and ameliorating the extent of damage.

We saw examples in our work where even though there were facilities close to where an injury took place, they were not made available and as a result the people did not get the kind of care they needed because sharing arrangements could not be worked out.

Obviously to the extent you can treat people in a place more proximate to where the injury or illness occurred, as well as meet their needs more quickly when they need specialized attention, the quality of care will increase and long-term suffering of the patient is going to be less.

Senator **Percy**. How might a strong peacetime DOD-VA sharing program, such as is envisioned in S. 2958, be possibly useful in times of war?

Mr. **Ahart**. We think it is important in terms of a precedent being set. To the extent that an effective peacetime sharing program can be implemented people would gain more experience in sharing and working out mutual arrangements. Therefore a higher degree of cooperation during wartime would be facilitated. We have done a study on the contingency medical care system of the Department of Defense and its efforts in that area. I think it would be useful to this committee to have Mr. Dutton say a little bit more about this matter.

Mr. **Dutton**. Mr. Chairman, we recently issued a report on DOD's military/civilian contingency hospital system and in our opinion the Nation should prepare for a possible conflict by planning to appropriately use Federal medical resources before calling on civilian resources. We believe that a contingency hospital system should make use of VA's medical resources for all categories of returning casualties including those who will return to duty and not just those who expect to be discharged to the VA's care.

Moreover, we believe a strong peactime medical resource sharing program such as we recommended in June 1978 and is addressed by S. 2958 could provide a sound foundation for establishing effective working relationships between VA and DOD which could be invaluable in the event of war. Consequently, in our recent report, we recommended that the Congress do three things.

One, give VA the mission of providing direct medical support to DOD for treating all categories of battlefield casualties.

Two, place battlefield casualties above veterans with non-service-connected, nonemergency conditions in VA's priority for care.

And three, remove the obstacles to interagency sharing in the peacetime setting that we earlier identified.

We believe that would be very helpful, Mr. Chairman.

Senator PERCY. Thank you very much, indeed. That is quite valuable. I wonder if Mr. Baine or Mr. Yohey have any comments to add?

Mr. BAINE. I don't believe so, Mr. Chairman.

Mr. YOHEY. No, sir.

Senator PERCY. Thank you very much. We will submit some questions to you to answer for the record.

[Mr. Ahart's prepared statement and answers to written questions follow:]

PREPARED STATEMENT OF GREGORY J. AHART

Mr. Chairman and members of the Committee, we are pleased to be here today to discuss S. 2958, a bill to encourage Federal agencies to share medical resources on an interagency basis.

We share the concern, expressed in your remarks in introducing an earlier version of this bill, that if the Congress is going to succeed in balancing the budget in fiscal year 1981 and beyond without jeopardizing essential services to American citizens, every effort must be made to eliminate waste and inefficiency in Government. In our opinion this bill constitutes a legislative statement of policy and guidance needed by the Federal Government's two largest direct health care systems--the Department of Defense (DOD) and the Veterans Administration (VA)--to more efficiently spend the billions of dollars appropriated annually to them for construction and renovation of health care facilities, purchase of medical supplies and equipment, and medical personnel.

This legislation addresses the obstacles to interagency sharing of medical resources identified in our report "Legislation Needed to Encourage Better Use of Federal Medical Resources and Remove Obstacles to Interagency Sharing" (HRD-78-54, June 14, 1978).

We believe that increased sharing would benefit the Federal Government by providing opportunities for:

--Eliminating or consolidating underused or duplicative facilities, equipment and staff.

San Diego VA's response was enthusiastic and it offered to let Navy use the laser twice a week at no cost. However, in subsequent discussions with VA's Central Office, San Diego VA officials were told that a fee was needed and that it would be highly unlikely that any no-fee contract would ever be approved. San Diego VA personnel were surprised by this opinion, because there would have been no real additional local costs. The laser was used for research, and Navy was going to use it on off-time.

Discussions over what fee to charge took several months, and the final VA proposal was unacceptable to the Navy. San Diego VA officials felt that $25 for each patient without cost for subsequent treatments on the same patient would be fair. VA's Central Office, however, stated that although San Diego VA had justified the $25 patient fee, a more appropriate rate would be the then $39 interagency rate specified for all outpatient visits. The $39 was to be charged for each treatment, while the price the Navy paid in the community was an initial $50 charge with no subsequent charges for additional treatment.

The VA's Central Office eventually disapproved the proposed sharing agreement because, in addition to the question of proper charge, an incorrect title for the agreement was used and the wrong authority for sharing with the Navy had been cited. As a result the Navy has bought its own laser unit for $28,500.

Also, physicians at the San Diego Naval Hospital needed an alternative source of providing cardiac catheterizations to Navy beneficiaries, and pursued negotiations with San Diego VA, which had an acceptable laboratory. Navy estimated about 700 patients would be catheterized in its laboratory, more than the maximum a single laboratory could handle in a year. On the other hand, VA's laboratory was catheterizing about 150 patients a year at the time.

Navy had alternatives to approaching VA--e.g., build a second catheterization laboratory, request area referral military hospitals to send their patients elsewhere, or refer retired and dependent patients to civilian providers--but wanted to explore the possibility of using VA's laboratory. VA would have benefitted by an increased workload, which would (1) enhance the resident training program, and (2) further justify the laboratory's existence.

The lack of incentives to share as well as no provision for any reimbursement back to the providing hospital eventually resulted in the failure to enter into a sharing arrangement.

BACKGROUND

Over the years, increasing concern has been expressed in the Congress and elsewhere over the rapidly increasing costs of medical care. As in the private sector, Federal agencies' costs to provide health care directly to eligible beneficiaries have continued to rise, and efforts have been made by the Federal agencies to explore ways of reducing these costs without adversely affecting the quality of care provided to Federal beneficiaries.

In fiscal year 1980, about $10 billion of congressional appropriations were requested by the Government's major direct health care providers. Other Federal agencies, such as the Departments of State, Justice, and Agriculture, requested additional tens of millions of dollars for health care services.

The rising cost of health care is particularly important to DOD and VA officials because of their responsibilities for providing health care directly to the majority of eligible Federal beneficiaries. These agencies spent an estimated $9.1 billion in fiscal year 1979 to provide medical care to their beneficiary populations. Hundreds of millions of these dollars were for care provided outside the Federal Government's direct health care systems.

Until recently, each Federal agency planned its health delivery system in terms of having sufficient services for the beneficiaries for which the agency had primary health care responsibility without considering the needs and capabilities of other Federal agencies.

However, Congressional desire for greater sharing was expressed in the Heart Disease, Cancer, and Stroke Amendments of 1965 (42 U.S.C. 299-299j) and the Comprehensive Health Planning and Public Health Service Amendments of 1966 (42 U.S.C. 246). The purpose of the legislation was to improve the level of health care in the Nation by increasing regional cooperation. The Comprehensive Health Planning and Public Health Service Amendments of 1966 authorized the creation of organizations to encourage cooperation between governmental and nongovernmental agencies, organizations, and groups concerned with health services, facilities, or manpower.

In addition, the National Health Planning and Resources Development Act of 1974 (Public Law 93-641, 42 U.S.C. 300 et seq.) required non-Federal hospitals to coordinate and plan the use of their medical resources in order to improve the quality of care and avoid duplication of resources. Although VA's participation in local health planning was provided for in the act and other Federal agencies were included in advisory capacities, no interaction between VA, DOD, and the Department of Health and Human Services' (HHS') direct health care systems was required.

Recognizing the unprecendented changes in the organization and delivery of our Nation's health care, a unified position on interagency sharing was taken by high-level representatives of the Government's major direct health care systems. In early 1978, the Assistant Secretary of Defense

(Health Affairs), the Surgeons General of the Armed Services, HHS's Assistant Secretary for Health, and VA's Chief Medical Director agreed that one approach to providing the highest possible quality of care with the greatest efficiency was to accept common goals and share resources. A Committee called the Federal Health Resources Sharing Committee (Sharing Committee) was established in February 1978. Its broad goal was to improve the overall quality of health care and reduce the excess consumption of scarce resources through coordinated planning arrangements.

The Sharing Committee committed itself to identify and promote opportunities for jointly planning and using the Government's health care resources. It provided a forum for agency medical representatives to cooperatively explore opportunities to share services and resources.

The Committee developed its scope of activities to include the following:

--Define and clarify the scope of joint planning and sharing.

--Advise Federal agency officials on cooperative opportunities and restraints.

--Identify and recommend legislative, regulatory, or other policy changes needed to enhance joint planning and sharing.

--Initiate, validate, and recommend coordinated programs that give the highest payoff in reducing unwarranted duplication or excess capacity, but avoid adversely affecting efficiency, effectiveness, readiness, or quality.

- --Clarify and recommend costing and funding provisions for interagency sharing agreements.
- --Establish subcommittees to explore joint planning and sharing arrangements in specific health care areas and develop criteria standards, when appropriate.

To accomplish its goals and objectives, the Sharing Committee has used several legislative authorities which permit Federal interagency sharing. However, in our opinion, these authorities do not give agency officials the uniform and comprehensive legislative guidance needed to implement a full and effective interagency medical resources sharing program.

For example, the Economy Act, 31 U.S.C. 686, permits a Federal hospital to request the services of another Federal hospital. The act was designed to allow Federal agencies' resources to be used to capacity and avoid unnecessary duplication and overlap of activities. In regard to the sharing of medical resources, the statute is permissive, except for three limitations: (1) both hospitals must be Federal hospitals, (2) the providing facility must be reimbursed on the basis of actual costs, and (3) the providing agency must be able to provide the service without increasing its resources. The Economy Act represents the only broad authority under which military hospitals may provide medical services to other agencies' beneficiaries.

VA, which administers the largest health care system under unified management in the Nation and uses a significant portion of the Nation's total health care resources, is authorized under 38 U.S.C. 5053 to share "specialized medical resources" with other hospitals and clinics (Federal, State, local) and medical schools.

Although fairly broad in scope, 38 U.S.C. 5053 does not give VA unlimited sharing authority. The most important limitation is that the statute covers only "specialized medical resources." These are defined as medical resources (whether equipment, space, or personnel) which because of cost, limited availability , or unusual nature, either are unique in the medical community or can be fully used only through mutual use. Secondly, VA must be reimbursed the full cost of services. Finally, sharing arrangements negotiated under this authority may not decrease the quality of care provided eligible veterans. Beyond these restrictions, the statute is permissive. It does not restrict fund transfers, patient transfers, or staff mobility except insofar as these are indirectly affected by the above limitations.

VA facilities may share equipment and facilities at no charge with DOD under 38 U.S.C. 5003. However, this statute does not provide for sharing medical services.

As part of its standard operating procedures, the Sharing Committee has established subcommittees to (1) develop and propose guidelines and criteria for assessing and justifying the need for and appropriate location of specialized medical services, (2) develop and propose program utilization criteria, and (3) explore sharing opportunities in specific geographic areas. Such subcommittees include the Cardiac Catheterization Laboratory Subcommittee, the Computerized Tomography Subcommittee, and the Cancer Treatment Facility Subcommittee.

In January 1980, the Chairman of the Sharing Committee approved the establishment of a Legislation Subcommittee. Its purpose was to provide the Sharing Committee with a review of the existing impediments to resource sharing along with recommended actions for removing these barriers where possible. The Subcommittee members represented the Army, Navy, Air Force, Department of Defense (Health Affairs), Public Health Service, and the Veterans Administration. Between January 25 and July 2, 1980, the Subcommittee held 18 meetings to complete its assigned tasks. A final Subcommittee report to the Sharing Committee was issued in July 1980.

GAO REPORTS ON INTERAGENCY SHARING OF MEDICAL RESOURCES

Our Office has invested considerable staff resources during the past 5 years in dealing with issue of sharing of Federal health care resources.

Some of the more specialized and highly expensive medical resources capable of being shared among Federal agencies have been discussed in our reports. Other reports have focused on the need to build new DOD and VA hospitals of proper size. The sizes of such new facilities should be dependent on the ability of Federal hospitals in immediate geographic areas to make effective use of existing resources, thereby avoiding the expenditure of additional Federal funds for unnecessary construction. Appendix I to this statement lists our reports which directly and indirectly address opportunities for interagency sharing of Federal medical resources.

Many of our reports concern matters ultimately considered by the Sharing Committee in its attempt to implement an effective sharing program among its member agencies. However, the Sharing Committee-directed efforts over the past 2 1/2 years by the many medical and administrative support personnel from DOD, VA, and HHS have not, in our opinion, resulted in substantive progress in implementing an effective Federal interagency sharing program. However, its efforts are continuing.

This is not to say that no sharing is taking place between individual health care facilities in the Federal sector. For example, Army data for fiscal year 1979 indicate that the Army facilities provided VA beneficiaries with about $7.4 million of inpatient and outpatient services. This total was based on a total of 26,594 inpatient days reimbursed at a DOD interagency rate of $253 per day and an additional 27,755 outpatient visits reimbursed at the DOD interagency rate of $25 per visit. The Tripler Army Medical Center in Hawaii accounted for a large portion--14,656 inpatient days and 15,422 outpatient visits--of this total.

There is an incomplete data base for ascertaining the total services provided among Federal facilities. The Sharing Committee has recognized this situation and has called for Federal facilities to report on both the types and dollar values of shared services.

It is important to note that this is being accomplished in the absence of a legislatively established environment which specifically encourages sharing. S. 2958 would establish such an environment, this in turn could pave the way for substantially increased sharing of direct medical care resources. The sharing of medical resources--particularly the more specialized and expensive--has the potential for significantly larger pay-offs in terms of budget savings to the Government and the taxpayers.

OBSTACLES TO SHARING

The basic reasons for the overall lack of substantive progress being made in taking advantage of the sharing opportunities were identified in our June 1978 report "Legislation

Needed to Encourage Better Use of Federal Medical Resources and Remove Obstacles to Interagency Sharing."

Our report was requested in January 1977 by the Chairman of the House Appropriations Committee. In addition to asking us to identify opportunities for Federal health care providers to share their resources, we were asked to identify legislative and administrative obstacles which may preclude sharing. The Chairman was particularly interested in our recommendations to overcome these obstacles.

In response, we visited or contacted officials at 50 Federal medical facilities in several areas of the United States and at the headquarters offices of the Federal agencies having major responsibilities for providing health care directly to beneficiaries. Because we focused on identifying obstacles to sharing and ways to overcome them, we did not attempt to identify all sharing opportunities which may have existed in the geographic areas we reviewed.

In most instances, one or more of the following obstacles precluded attempts by, or inhibited the efforts of, local Federal officials to reach satisfactory interagency sharing arrangements.

--The absence of a specific legislative policy for interagency sharing and a lack of adequate headquarters guidance on how to share.

--Restrictive agency regulations, policies, and procedures.

--Inconsistent and unequal reimbursement methods.

We believe that attempts to share, whether initiated at the local Federal hospital level or by an interagency group at the departmental level, such as the Sharing Committee are hindered by the same types of obstacles.

Lack of Specific Legislative and Adequate Headquarters Guidance

Although numerous laws authorize beneficiaries from one Federal agency to be treated in another Federal agency's facility, none are explicit concerning what categories of beneficiaries can be served. Of the laws, the Economy Act (31 U.S.C. 686) could probably best be used to share. Other laws such as VA's sharing law (38 U.S.C. 5053) or PHS' sharing law (42 U.S.C. 254a), could also be used. However, these laws are interpreted differently by the agencies. This condition exists to some extent because the Congress has not enacted legislation which clearly specifies its expectations concerning interagency sharing.

For example, in June 1976 the Conference Report on DOD's 1977 military construction appropriations request provided policy guidance to DOD--which had no specific legislative sharing authority--on interagency sharing. The report directed DOD to:

--Develop policies to make maximum and cost-effective use of existing Federal hospitals.

--Coordinate the planning of future bed capacity with other Federal health care representatives.

While this guidance has helped DOD plan the size of new military hospitals, the only specific legislative authority by which DOD could share remained the broad authority in the Economy Act enacted in 1915.

In essense, the Congress has told DOD to share with other Federal agencies, but has given no legislative authority to supplement the Economy Act to accomplish this task. The Congress has not provided (1) legislation to require interagency sharing when appropriate or (2) uniform guidance to all Federal agencies on sharing.

Because of this lack of a legislative policy, Federal agencies have been unable to establish an effective Federal interagency medical sharing program. In agency officials' opinions, the individual health care systems were established to serve specific beneficiaries. Some agency officials believe that to provide extensive care for another Federal agency's beneficiaries could adversely affect their abilities to perform their primary missions. In an overall sense (and notwithstanding the work of the Sharing Committee) interagency sharing has been given low priority within Federal agencies and, as might be expected, there are currently no uniform policies, regulations, or procedures. Therefore, little consistent guidance is provided by the headquarters or command levels to hospitals or clinics attempting to enter into interagency sharing agreements.

Restrictive Regulations Policies, and Procedures

Agency regulations, policies, and procedures, based on each agency's interpretation and implementation of existing legislation, inhibit interagency sharing. During our review, we identified several instances where Federal hospitals could have shared services but did not because the treatment was not for emergency purposes or because beds, although available, had not been allocated in advance for use by another agency's beneficiaries.

We focused on DOD and VA regulations, policies, and procedures, since they are the largest Federal direct health care agencies. PHS' sharing authority, however, is restricted similarly to VA's.

DOD restrictions on treating VA beneficiaries

As previously mentioned, the only broad sharing authority which DOD could use to share its resources with other Federal agencies (e.g., VA) is the Economy Act. However, military regulations impose restrictions on providing services to VA beneficiaries under this authority.

For example, Army regulations place restrictions on VA's beneficiaries being treated in Army facilities. While authorizing care for eligible beneficiaries of other Federal agencies on a reimbursable basis under the authority of the Economy Act, the regulations limit Army inpatient care for VA beneficiaries to emergencies and cases where beds have been allocated by prior agreement. Navy and Air Force regulations place similar restrictions on treating VA beneficiaries.

Also Army regulations regarding outpatient care for VA beneficiaries are not clear. One regulation states that outpatient care, other than in emergencies, must be authorized in advance. The Army Health Services Command's Chief of Patient Administration at the time of our review told us that this rule implies that it is permissible to furnish outpatient care to veterans, but it is only an implication subject to individual interpretation. The chief also acknowledged that the Army really had no specific mission to treat VA beneficiaries.

This mission argument was raised in many of our discussions with agency officials. In most instances these officials believed in the sharing concept but thought that their medical facilities' missions would not permit such a radical departure from their current manner of operation.

VA restrictions on treating DOD beneficiaries

The Economy Act also permits VA to share its medical resources with other Federal agencies (e.g., DOD). However, in our opinion, VA has interpreted the Economy Act's authority rather narrowly and inconsistently.

During our review, a VA Central Office official told us that dependents of active duty and retired military personnel could be treated in VA hospitals if a formalized sharing agreement between a military hospital and VA were negotiated as specified in the VA sharing law (38 U.S.C. 5053). These same individuals would not be treated, according to this official, if a VA hospital had negotiated an interagency agreement under the Economy Act.

However, one of the interagency agreements in effect at the time of our review specified that active duty and retired military and their dependents, both men and women, would be eligible for cardiac catheterization in a VA hospital. This agreement, under the Ecomomy Act's authority, was inconsistent with what the VA Central Office official told us.

In response to our inquiry regarding this and other apparent inconsistencies in its application of sharing authorities, the Administrator of Veterans Affairs stated that its hospitals were authorized to provide medical services to all beneficiaries of other Federal agencies under the

Economy Act. However, the provision of such services at a VA hospital is dependent upon present capacity to provide such services without interference with the primary function, which is to deliver health care to veterans. The determination of capability to provide a requested service for other agencies' beneficiaries is administrative and may be expected to constantly fluctuate in direct relationship to veterans' care needs.

VA concluded that since it was not in a position to provide medical services to eligible dependent beneficiaries, it must contract for such services. Therefore, VA believed our questions concerning authority to share and the basis for recovery of costs under such arrangements were essentially moot. However, as we pointed out to the Administrator, VA hospitals were servicing active duty and retired military members and their dependents in several locations. In no instances were these services, according to the VA hospital officials involved, being provided to the detriment of VA's primary beneficiaries.

Overall, we found that VA's regulations restrict other Federal agencies' beneficiaries from receiving routine medical care. According to these regulations, active duty military personnel are approved for medical care if they require emergency hospital treatment or if they are potentially eligible as VA beneficiaries, because of forthcoming discharge from the Armed Forces. Outpatient treatment or examination in VA facilities must be authoried by the appropriate military departments. Retired members of the Armed Forces may receive hospital care or outpatient treatment on presentation of identification, when not otherwise eligible as a VA beneficiary. Dependents of active duty members will be given only emergency care. These regulations state that since VA does not have facilities for routine care and treatment of military dependents, such individuals will be transferred out of the VA system as soon as possible.

Restrictive VA sharing law

VA is permitted under its sharing law, 38 U.S.C. 5053, to share only specialized medical resources. The Chief Medical Director--VA's highest ranking medical official--determines what constitutes a specialized medical resource. Each resource considered for sharing is taken on its own merit in its particular geographical area. Therefore, a specialized medical resource in one area because of its cost, limited availability, or unusual nature may not be specialized and approved for sharing by the Chief Medical Director in another area.

Several VA hospital officials have told us that the VA Central Office has been too restrictive in interpreting which resources may be shared under this authority and therefore, sharing efforts are hindered. They believed that the law should be amended to allow sharing of every medical service, particularly between Federal facilities. VA Central Office officials also believed that sharing restrictions need to be relaxed.

Budgetary restrictions

Several sharing opportunities were unsuccessful because of VA's inability to budget for the care for another agency's beneficiaries. Consequently, equipment which could have been shared was not shared because the needed additional staffing was not available.

Another budgetary obstacle relates to the several alternative means DOD has for treating its own beneficiaries which favorably affects an individual military facility's health care budget but ultimately negatively affects possible opportunities to share Federal medical resources. These alternative means involve using CHAMPUS and transferring patients to other DOD facilities using the domestic areomedical evacuation system. 1/

1/Under this system, DOD airlifts patients under medical supervision in specially equipped aircraft to, between, and from its medical treatment facilities.

The availability of the CHAMPUS alternative creates a lack of incentive for local military hospital managers to use nearby Federal facilities. Under CHAMPUS, dependents of military personnel, military retirees and their dependents, and dependents of deceased military members may receive medical care in a civilian medical facility if the services needed are not available in any uniformed service medical facility.

Generally, for non-emergency inpatient treatment these patients must obtain a certificate stating that needed care is not available in any local uniform military facility within a 40-mile radius. CHAMPUS is funded under a separate DOD appropriation from that financing the operation of the facility issuing the nonavailabaility certificate. Consequently, the facility issuing the certificate has no incentive to seek care for CHAMPUS patients in a nearby Federal facility because it is not held accountable for the funds needed to pay CHAMPUS providers. On the other hand, referral of military beneficiaries to another Federal facility for treatment would likely involve a charge which would come out of the local military hospital's budget.

A similar lack of incentive exists in some instances when DOD hospitals use the domestic aeromedical evacuation system. The Air Force transports military beneficiaries from one military medical facility to another, and military medical departments using the service are not charged. Flights can be routed to pick up possibly just one patient at no expense to the requesting hospital thereby creating an incentive for DOD hospital officials to rely on this alternative rather than referring patients to nearby VA facilities on a reimbursable basis.

Time-consuming review of proposed sharing agreements

VA Central Office procedures for reviewing and approving proposed formal sharing agreements submitted by local VA hospital officials are unnecessarily complex and time-consuming. VA hospital officials told us that the time taken by VA's Central Office to review these proposals inhibits interagency sharing.

According to VA hospital officials, sharing would be facilitated by granting hospitals approval authority. One hospital director believed field officials should be authorized to approve contracts, agreements, or arrangements for sharing or exchanging medical resources. This authority should be subject to Central Office review and veto if the Central Office considered the agreement to not be in VA's or the Government's best interest. The local authority could, however, involve the necessary participants without having to wait long periods of time for Central Office review.

Inconsistent and Unequal Reimbursement Methods

Perhaps the major obstacle to sharing involves reimbursement. Simply stated, no standard reimbursement mechanism exists between agencies, no clear policy is evident for allocating reimbursements back to providing hospitals, and reimbursement rates differ between agencies. Without adequate reimbursement, hospital officials have no incentive for sharing.

Lack of standard reimbursement mechanism

VA uses two authorities--38 U.S.C. 5053 and the Economy Act, 31 U.S.C. 686--to share its medical resources with other Federal agencies.

Under 38 U.S.C. 5053, VA is required to obtain full reimbursement for any services provided and pay full costs for any services received. Full reimbursement means that VA must charge actual costs, including supplies used, and normal depreciation and amortization of equipment. Also VA may share only specialized medical resources at a level which will not reduce medical services to veterans. A formal sharing agreement is required, and services may be shared with Government, community, or private hospitals or clinics.

The Economy Act requires reimbursement based on actual costs. This reimbursement requirement has been satisfied by VA and other Federal agencies which use this authority by establishing, on an annual basis, daily inpatient and outpatient interagency rates, regardless of the service provided, based on total annual operating costs and the total annual inpatient and outpatient workloads. An interagency agreement, rather than a Title 38 sharing agreement, is required under the Economy Act.

Although both these authorities permit interagency sharing, the different reimbursement mechanisms restrict an active, continuing interchange of services. VA officials told us, for example, that from a budgetary standpoint there is a big incentive to provide services under the Title 38 sharing authority (38 U.S.C. 5053) rather than under an interagency sharing agreement under the Economy Act.

Essentially, to furnish a "carrot" encouraging VA's sharing, services provided under formal sharing agreement authority could result in double payment to the local hospital since (1) a patient referred from another facility is counted in the workload statistics used to request funds from the Congress with subsequent allocations to the hospital and (2) VA allocates total reimbursements for services provided under sharing agreements back to the providing hospital. On the other hand, services provided under interagency agreements are reimbursed to VA's Central Office on the basis of the daily inpatient and outpatient rates, regardless of actual cost of the specific services provided. However, the reimbursement is not allocated back to the individual hospital to help offset the expenses incurred.

Because of VA's policy, VA hospital directors usually insist on using a formal (38 U.S.C. 5053) rather than an interagency (31 U.S.C. 686) sharing agreement. 38 U.S.C. 5053, is used primarily by the VA for sharing with the private sector hospitals. However, Federal hospitals are permitted to share under this authority.

DOD's situation is not nearly as complex as VA's because DOD facilities have no sharing authority similar to VA's and sharing is done using interagency rates only. However, the same disincentive--lack of reimbursement--still exists.

DOD officials told us that their regulations do not allow providing hospitals to be reimbursed to the extent necessary to provide an incentive to share. The Army, for example, does not allow any direct local reimbursement. Navy allows a partial reimbursement of outpatient charges and Air Force indirectly reimburses its facilities through the budget process. Many DOD hospital officials told us they lacked an incentive to share because their facilities would not be reimbursed.

Failure to agree on reimbursement rates

In VA's dealings with other Federal agencies, full cost reimbursements are generally required before VA provides services to other Federal agencies' beneficiaries. On the other hand, DOD is willing to provide to procure services from other Federal agencies (e.g., VA) only on the basis of interagency rates. Full cost and interagency rates are rarely the same. As a consequence, sharing between these Federal agencies is limited because of their failure to arrive at mutually agreeable reimbursement rates.

Officials of the Army, Navy, and Air Force told us that unlike the VA's insistence on actual costs, the military departments require interagency rates for both purchasing and providing direct care and supplemental care to other Federal agencies.

GAO Prior Recommendations to Implement an Effective Interagency Medical Resources Sharing Program

In our June 1978 report we concluded that the Federal Government has a unique opportunity to take the lead in medical resources sharing. We believed that to take full advantage of this opportunity, however, required action by the Congress and a concerted effort by the involved agencies to eliminate obstacles to sharing and establish a Federal health care delivery system which would more efficiently use the direct health care systems administered by DOD, VA, and the Public Health Service.

We strongly believe that the legislative and administrative obstacles to sharing can be eliminated without adversely affecting the level or quality of care given to each agency's primary beneficiaries. Eliminating the obstacles and implementing a structured Federal interagency sharing program would benefit both the Federal Government and its health care beneficiaries.

After careful consideration of various alternative recommendations to overcome the obstacles we identified, we felt the paramount need was for legislation to require interagency sharing when appropriate and to encourage the establishment of Government-wide implementing procedures. Such legislation would encourage individual initiative without adversely affecting any Federal agency's current responsibilities or organizational and command structures. It would also give increased management options to local Federal medical officials to make the best use of our Nation's medical resources.

We recommended, therefore, that the Congress enact legislation which would:

- **--Establish a policy that directs interagency sharing of Federal medical resources when appropriate.**
- **--Authorize each Federal health provider to accept all categories of direct care beneficiaries on a referral basis when it would be advantageous to the Federal**

Government and care of providing facility's primary beneficiaries would not be adversely affected.

--Eliminate all restrictions on the types of medical services which can be shared between Federal facilities.

--Authorize field hospital managers to approve agreements between Federal facilities, subject to headquarters veto only if judged not in the best interest to the Government.

--Permit agencies to expand services to treat beneficiaries of another Federal agency when such services would benefit the patient and the Government.

--Establish a policy requiring Federal facilities to use, if practical, nearby Federal direct health care resources before referring patients for care under programs such as CHAMPUS or CHAMPVA 1/ or to distant facilities within their own health care systems.

--Authorize the establishment of a reimbursement mechanism based on negotiated costs with a provision to reimburse the providing hospital with any revenues received to offset any expenses incurred.

--Assign to the Office of Management and Budget the responsibility to (1) coordinate the implementation of an effective interagency Federal medical resources sharing program and (2) report annually to the Congress concerning the progress being made toward increased sharing of these resources.

GAO's Views on S. 2958

We believe that enacting legislation which establishes a Federal policy to promote Federal interagency sharing and removes restrictions on the types of services which can be shared would be both beneficial and timely in view of the

---

1/Civilian Health and Medical Programs of the Veterans Administration.

increasing concern regarding the spiraling costs of health care.

S. 2958 addresses the factors we believe are essential to the implementation of an effective interagency medical resources sharing program. Enactment of this legislation would also complement the national health priorities established by the National Health Planning and Resources Development Act of 1974 and provide the impetus and direction needed by Federal agencies to make interagency sharing more a rule than an exception.

Many S. 2958 provisions would carry out the intent of the legislative proposal presented in our June 1978 report and are important and necessary to accomplishing the bill's purpose.

Before addressing specific sections of the bill, I would like to suggest that the Committee include the Department of Health and Human Services in the bill, and also include the Department's Secretary as a member of the Sharing Committee envisioned by S. 2958. We recognize that DOD and VA represent the majority of the Federal Government's direct health care resources and are responsible for the provision of health care to the largest segments of the Federal beneficiary population. Nevertheless, HHS, through its Public Health Service and Indian Health Service direct health care systems, provides care to a substantial Federal beneficiary population, including many persons with current or future eligibility for care in military and/or VA facilities. We believe that the inclusion of HHS would further enhance your proposal for the implementation of an effective interagency medical resources sharing program.

Our specific comments on several of the bill's provisions follow:

--Section 2. (a)(4) recognizes the importance of each agency's current responsibilities, and therefore, its mission. This is important to the agencies and we believe the agencies' implementation of this legislation would enhance the ability of each agency to seek and obtain alternative sources of care for the beneficiaries while controlling rising health care costs.

--Section 2. (b) states that the purpose of this Act is to expand and clarify the authority of the VA and DOD as direct health care providers in order to facilitiate Federal interagency sharing of medical care and medical care support resources. This section is important because the resources to be shared would not be limited to direct medical services, but would include the ancillary support services (i.e. administrative, laboratory, laundry, etc.) needed by Federal direct health care providers.

--Section 3. (5) defines "negotiated costs" as the cost for services provided between Federal facilities as determined by local hospital officials on a medical service-by-service, hospital-by-hospital basis in an equitable and consistent manner.

We believe a "negotiated" cost rather than an "actual", "full" or "reasonable" cost as currently provided for in existing sharing legislation is needed if an effective sharing program is to be implemented. These latter categories of costs do not necessarily represent the true "out-of-pocket costs" of providing services since costs such as salaries and utilities would be incurred whether or not services were provided to other agencies' beneficiaries.

Any reimbursement mechanism adopted by the agencies should be flexible enough to encourage and permit negotiations between local Federal hospital officials to determine acceptable rates of reimbursement for services shared. Negotiated reimbursements could be based depending on individual circumstances, on all costs funded from current appropriations, incremental costs (costs in excess of fixed costs for an additional item of service), or some other cost which is mutually agreed upon. As HHS suggested in commenting on the draft of our June 1978 report, it might even be desirable to share resources by means of even exchange (no reimbursement). In any case, if the reimbursements are agreeable to both parties, sharing will take place.

Also, as provided in Sec. 4. (a)(6)(7) the reimbursement must be credited to the specific facility which provided the medical service. Without such a provision, the incentive at the local Federal hospital level to share is diminished or lost. In addition, the same subsection allows funds received as reimbursement for services provided to be obligated in the fiscal year following the fiscal year in which the medical service was provided. We endorse this provision because without it funds received from sharing arrangements would have to be obligated within the same fiscal year the medical resource is shared. This could cause administrative problems near the end of each fiscal year and thereby reduce the incentive for local facilities to foster continuing sharing programs. This provision should also obviate the need for possibly substantial end-of-year spending of proceeds from sharing arrangements.

As the agencies' willingness to share their resources increases and their cost accounting systems become more sophisticated, it seems reasonable to expect that incremental costs could eventually become the standard basis of reimbursements for medical resources shared between Federal agencies.

--Section 4(a) of the bill establishes a Federal Interagency Health Resources Committee to coordinate the interagency sharing of medical resources. The Committee would be comprised of the Secretary of Defense and the Administrator of Veterans' Affairs. These officials would be held accountable by the Congress for fulfilling the responsibilities contained throughout Section 4 of S. 2958.

In our recommendation to the Congress for implementing an effective Federal medical resources sharing program, we recommended that responsibilities similar to those contained in Sec. 4 be assigned to the Office of Management and Budget (OMB). However, OMB has consistently taken the position that the more formal oversight and coordination we recommended was not necessary. Instead, OMB, when considering interagency sharing issues, prefers to rely on its budget examiners and other staff already working with the affected agencies.

S. 2958 clearly delineates Congressional policy on the issue of sharing medical resources and specifies that the Federal Interagency Health Resources Committee's primary responsibility is to fully and effectively implement this congressional policy. The formal congressional recognition of the Committee as the leader in this interagency effort satisfies the intent of our report recommendation.

--Section 4. (c) permits the agencies to request from Congress relief from personnel ceilings or other restrictions as well as funding needed to treat other Federal agencies beneficiaries. Such requests must be substantiated by the providing agency.

We endorse the personnel ceilings relief provided by this bill. However, such relief should be used in a prudent manner and only in instances when it would be cost-effective to the Federal Government as a whole. Our field work has indicated that personnel ceilings are a major impediment to the sharing of medical resources among Federal agencies.

We believe that if Government agencies are to effectively, efficiently, and economically accomplish the programs and functions authorized by the Congress, they must judiciously use the most appropriate kinds of manpower capable of producing the desired results. There is general agreement that civilian and military employment must be controlled, but opinions differ about the effectiveness of different control techniques.

We have suggested that funding or program limitations seemed to be an effective means of controlling the number of persons an agency can employ. Additional controls imposed by personnel ceilings deprive agency management of options for accomplishing activities such as interagency sharing through the most effective, efficient, and economical arrangements. In our opinion, the bill's requirement for specific justification of such requests is sufficient to insure proper use of staffing and other resources.

Moreover, we believe additional funding should, as the bill permits, be authorized upon specific justification that it would be most cost-effective to treat beneficiaries of one agency in direct health care facilities of another agency.

Finally, the focus of S. 2958 and our testimony have pertained to the establishment of a strong peacetime medical resources sharing program. However, a closely related issue involves the extent of support VA can provide DOD in treating battlefield casualties. Our recently issued report "The Congress Should Mandate Formation of a Military-VA-Civilian Contingency Hospital System" (HRD-80-76, June 26, 1980) discusses this important issue.

The most important issue in this report relative to sharing Federal medical resources is that VA believes it cannot fully support DOD in treating casualties expected to return to duty without legislative modification to its current responsibilities. In fact, the Administrator of Veterans Affairs recently told DOD that VA would not be able to directly support DOD in treating wartime casualties in the United States unless it is given that mission in other than a declared national emergency.

We believe that a contingency hospital system which makes use of VA's medical resources for all categories of returning casualties would be an efficient and effective use of Federal medical capability. Moreover, we believe that a strong peacetime medical resource sharing program, such as S. 2958 mandates, could provide a sound foundation for establishing effective working relationships between VA and DOD. Such a program would be invaluable in the event of war.

- - - - -

We continue to believe the Federal Government has a unique opportunity to take the lead in medical resource sharing and to serve as a model for proper health resources planning and use. In our opinion, the Congress' enactment of S. 2958 would represent a significant step forward in that direction by creating an environment in which Federal agencies could make the most cost-effective use of their medical resources while maintaining, or perhaps enhancing, the quality of care provided to their many beneficiaries.

This concludes my statement. We will be happy to answer any questions you might have.

GAO REPORTS DEALING WITH OPPORTUNITIES FOR SHARING OF FEDERAL MEDICAL RESOURCES

"Policy Changes and More Realistic Planning Can Reduce Size of New San Diego Naval Hospital" (MWD-76-117, April 7, 1976)

"Congressional Policy Guidance Should Improve Military Hospital Planning" (HRD-77-5, Nov. 18, 1976)

"Many Cardiac Catheterization Laboratories Underused in Veterans Administration Hospitals: Better Planning and Contrtol Needed" (HRD-76-168, Feb. 28, 1977)

Letter Report on "VA's Process to Determine Size of New and Replacement Health Care Facilities" (HRD-77-104, May 20, 1977)

Letter Report on "Operation of PHS Hospitals and Clinics as Required by Public Law 93-155" (HRD-77-111, May 26, 1977)

"Sharing Cardiac Catheterization Services: A Way to Improve Patient Care and Reduce Costs" (HRD-78-14, Nov. 17, 1977)

"Computed Tomography Scanners: Opportunity for Coordinated Federal Planning Before Substantial Acquisitions" (HRD-78-41, Jan. 30, 1978)

"Constructing New VA Hospital in Camden, New Jersey Unjustified" (HRD-78-51, Feb 6, 1978)

"Inappropriate Number of Acute Care Beds Planned by VA for New Hospitals" (HRD-78-102, May 17, 1978)

"Better Coordination Could Improve Provision of Federal Health Care in Hawaii" (HRD-78-99, May 22, 1978)

"Legislation Needed to Encourage Better Use of Federal Medical Resources and Remove Obstacles to Interagency Sharing" (HRD-78-54, June 14, 1978)

"Federal Hospitals Could Improve Certain Cancer Treatment Capability by Sharing" (HRD-79-42, Feb. 7, 1979)

"Military Medicine is in Trouble: Complete Reassessment Needed" (HRD-79-107, Aug. 16, 1979)

"Health Costs Can be Reduced by Millions of Dollars If Federal Agencies Fully Carry Out GAO Recommendations" (HRD-80-6, Nov. 13, 1979)

"Inpatient Care at Quantico Naval Hospital Should Not be Resumed" (HRD-80-26, Nov. 29, 1979) and

"The Congress Should Mandate Formation of a Military-VA-Civilian Contingency Hospital System" (HRD-80-76, June 26, 1980)

GAO RESPONSES TO QUESTIONS SUBMITTED BY
SENATOR CHARLES H. PERCY
CONCERNING INTERAGENCY SHARING OF MEDICAL RESOURCES

1. Background:

The numerous GAO reports on interagency sharing which are listed in Appendix I to your testimony are evidence of GAO's commitment and allocation of staff resources over the last 5 years to this important issue.

Question:

To what extent should we expect GAO's work in this area to continue if S. 2958 is enacted into law?

Response:

Following enactment and initial implementation of the act by the agencies, we would expect to review the progress of its implementation to see if it has had the expected positive effect on interagency sharing. We believe that the provisions of S. 2958 dealing with the agencies' responsibilities for reporting on their progress along with our review activities should provide the Congress with sufficient information to judge the adequacy of the agencies' implementation of the act.

2. Background:

The GAO's June 1978 report on obstacles to sharing concludes on page 29 that the lack of an effective reimbursement mechanism is the major obstacle at the individual Federal hospital and clinic level to increased interagency sharing.

Question:

What action, in your opinion, can and should be initiated to resolve this problem?

Response:

S. 2958 eliminates the principal reimbursement obstacles to effective interagency sharing by (1) authorizing reimbursements based on negotiated costs to be agreed to by local facility directors or commanding officers and (2) requiring reimbursements received under sharing arrangements to be credited to the local facility which provided the medical resource.

We believe that the reimbursement mechanism should be flexible enough to permit negotiations between local hospital officials to determine acceptable rates of reimbursement for resources shared. These rates could range from no reimbursement to reimbursement of full costs of providing resources. Any attempts by the Defense Department or the Veterans Administration to standardize sharing reimbursement rates on a medical service-by-service basis for use at each of their health care facilities would hinder local hospital officials' efforts to share their medical resources.

The importance of crediting the reimbursements from sharing back to the providing facility cannot be overemphasized. This principle represents the major incentive at the local level to encourage sharing. If local Federal hospital administrators are assured that their facilities' costs for providing resources to another agency's beneficiaries will be reimbursed, hospital officials should, in our opinion, be more inclined to seek opportunities to share medical resources.

We believe the agencies should immediately begin efforts to agree on the mechanism and administrative procedures to be followed in implementing these provisions of S. 2958. This action should be taken regardless of the eventual outcome of S. 2958.

3. Question:

In your extensive work regarding the sharing issue, what has been your impression of how physicians and other members of the health professions in the Federal hospital feel about sharing with other agencies?

Response:

In our work over the past 5 years relating to the interagency sharing of medical resources, we have visited about 90 Federal facilities throughout the country. Our overall impression is that most Federal physicians and other health professionals working in these facilities would welcome the opportunity to treat beneficiaries of other agencies. This appears to be true for a number of reasons.

First, they generally believe that this would be better for the patients. In certain cases, the patients would not have to travel long distances for care. Also, patients could save money. For example, patients currently being treated in the CHAMPUS program under cost-sharing arrangements could save significant amounts of personal expense if their care could be provided for free in a VA facility. Similar savings could occur if VA beneficiaries under a similar program (CHAMPVA) were treated in a Defense Department facility.

Secondly, they believe that they would benefit greatly by broadening their professional experiences through increased opportunities to see and treat different kinds of patients with a wider range of medical disorders. This appeared to be especially true of the VA providers who in many cases desired the benefits to be derived from treating a full range of Defense Department beneficiaries, including women and children.

Federal health providers who were in favor of interagency sharing were convinced that greatly increased sharing could occur without adversely affecting their facilities' responsibilities to their own beneficiaries. Most medical professionals who were opposed to sharing did not base their views on any adverse impact of the quality of care caused by interagency sharing on their respective agency's beneficiary populations. Instead, their views appeared to be centered on the perceived lack of authority for one agency to treat another agency's beneficiaries.

Senator PERCY. Our next panel consists of Rear Adm. J. William Cox, Commanding Officer, Naval Regional Medical Center; and Mr. F. Todd Yates, Chief of Supply Service, Veterans Administration Hospital in San Diego.

We welcome both of you. Admiral Cox, I want to congratulate you on your forthcoming appointment as Navy Surgeon General. I take particular pride in that, the Navy being my own branch of the service. I had the pleasure of serving for 3 years.

I would like to welcome you both this morning. You have offered to appear and describe the attempts by the Navy and VA Hospital in San Diego to enter into sharing agreements and also to comment on why these attempts have failed.

Admiral Cox, could you describe the background of the case, what benefits to your hospital and the Federal Government could have been realized had your agreement been successful? And could you tell us what obstacles you encountered and how S. 2958 might have been helpful to you in your efforts, and any other thoughts on how the bill might help local administrators and save money, it would be appreciated.

I understand you have no prepared statement but we will be happy to have you make any comments you care to make.

TESTIMONY OF REAR ADM. J. WILLIAM COX, COMMANDING OFFICER, NAVAL REGIONAL MEDICAL CENTER, SAN DIEGO, CALIF.

Admiral Cox. Thank you, Mr. Chairman. It is a pleasure to be here. My comments are strictly from the perspective of a Regional Health Facility Commander. I was not the incumbent at the time the difficulties arose, but I have verified the accuracy of the scenario.

The circumstances were that patients needing laser beam therapy were being referred to the civilian community at a cost of $50 per patient, irrespective of the number of visits that were required. The treatment modality was relatively new at that time and was increasing in number. So difficulties were encountered.

We approached the Veterans' Administration for use of an underutilized argon laser beam and it was agreed by the local officials that that was appropriate and it was offered for two afternoons a week. However, it was necessary for the agreement to be cleared by VA central headquarters in accordance with their departmental regulations.

Discussions came about as to what was the appropriate interagency compensation and it was settled on to be the interagency per diem outpatient rate, which was $39. Unfortunately, it would have been $39 per visit with oftentimes six or more visits required.

So a comparative cost to the Naval Regional Medical Center would have been $234 per patient instead of $50 per patient. Obviously, alternatives had to be sought. The sharing fell through and a new laser costing about $28,500 was purchased by the Navy.

A second example was even more significant. It had to do with the high level technology of a cardiac catheterization laboratory, which existed at both institutions. We had a very large clientele and were doing about 750 cardiac catheterizations per year at that time, which exceeded our logistical capabilities.

The VA was approached in an attempt to supply our own personnel and our own disposable supplies if we could use the expensive equipment of their cath lab. They were only doing about 150 per year. This too was tentatively agreed to but fell through because of the requirements for reimbursement at the inpatient interagency per diem rate.

So it would have been expensive to the Naval Regional Medical Center and of no direct financial value to the operations of the Veterans' Administration hospital in San Diego.

Subsequently, we have continued in dialog and discussions. We do have a number of sharing arrangements which I will not detail but the dialog between the two institutions has continued.

In view of the past, we would welcome this legislation, if the bill could provide for the elimination of the roadblocks to the sharing of existing facilities of all Federal Health Care Service facilities. It would be very beneficial. It would preclude some of the nightmares and provide the incentives to get on with interagency and local planning, so long as it was monitored, not directed from a central facility—local commanders worried about that—monitored to be sure what we are doing is reasonable rather than setting a goal that would cause more difficulties between two institutions. I stand ready for any questions, Mr. Chairman.

Senator **Percy**. Thank you very kindly, Admiral.

Mr. Yates, would you care to make some comments?

TESTIMONY OF F. TODD YATES, CHIEF, SUPPLY SERVICE, VETERANS' ADMINISTRATION MEDICAL CENTER, SAN DIEGO CALIF.

Mr. **Yates**. Mr. Chairman, I am Todd Yates, chief, Supply Service, at the Veterans' Administration Medical Center, San Diego, Calif. I have been asked to recite several of my experiences at the San Diego Medical Center which relate to the sharing of medical resources between Federal agencies.

In addition, I have been asked to comment on the effects of Senate bill S. 2958 if it had been enacted as law at the time that the San Diego Medical Center was attempting to negotiate interagency sharing arrangements.

The first experience occurred when the San Diego Naval Regional Medical Center approached the VA Medical Center regarding the possibility of using our laser for treatment of eye disease in Navy dependents.

I have been asked at this point in my testimony to define the term laser. In this instance, a laser is simply a medical device designed for use in surgical procedures on the eye.

As the Navy intended to use the laser during periods when it was not scheduled by the VA and further intended to accomplish the procedures with their own staff, there was no significant direct cost to our medical center. On this basis, the request was favorably accepted by the VA Medical Center and we looked forward to the opportunity to share this valuable resource, without cost, to the Navy.

At the time this arrangement was proposed, the VA had no published standard format for interagency agreements and we therefore developed a simplified version of a sharing agreement. At this same time, we were advised by VA officials in Washington, D.C., that under the Federal Economy Act we were required to obtain reimbursement.

In an effort to establish a fee type arrangement which would still be desirable to the Navy, we submitted our proposed agreement to Washington, D.C., citing a one-time use fee of $25 per patient. The $25 fee was justified as the prevailing rate in the community for use of the laser at Mercy Hospital, a privately operated facility.

Although the Navy paid $50 for use of this laser, other private institutions which had financially participated in the laser's purchase paid only $25. The agreement was ultimately returned with the advice that a more appropriate rate would be the current OMB approved interagency rate of $39 per outpatient visit.

This rate was to be applied to each treatment rather than being a one-time-use fee per patient as was common practice in the community. As a result, the cost for use of this medical center's laser was greater than in the community and the Navy never did use our laser even though an approved interagency agreement existed.

I have also been asked at this point to refer to the chart here in terms of the costs or the options that were available to the Navy. When the Navy first came to us, on the first line there on the chart, as I understand it, they were paying $50 per patient for use of a laser at a community facility.

The original proposal of an interagency agreement between the VA and Navy was for a no charge use of the VA's laser at the San Diego Medical Center. That is line 2. The ultimate proposal which was approved by the agency was a $39 per patient visit fee, as indicated on line 3 on the chart.

At approximately the same time that we were attempting to establish an agreement for Navy use of our laser, we were also approached by the Navy regarding accomplishment of a portion of their cardiac catheterization load at this medical center. As we had the capacity to accomplish additional workload, we tentatively agreed and proceeded to include this service in the agreement covering use of the laser.

As we were now aware of our agency's requirement for reimbursement at the OMB approved interagency rate, the service was priced accordingly. Whereas in the case of the laser there was no significant cost in providing the service, the cost of the materials required to accomplish a cardiac catheterization and the cost of inpatient care were seen as having a very significant impact on our budget.

In attempting to confirm the availability of Navy payments for reimbursement of our direct costs, we were advised by VA officials in Washington, D.C., that funds received from the Navy could not be made available to this medical center. To temporarily offset this deficiency an informal agreement was reached providing for the Navy to furnish all disposable supplies used in the procedure. At the same time, we prepared a sharing agreement which would allow local reimbursement and priced the procedure at actual cost. Although the Navy used our facilities for a short period of time under the terms of the interagency agreement, both institutions ultimately lost interest in the arrangement due to the difficulties encountered. The proposed sharing agreement was never accomplished and the interagency agreement was allowed to expire due to inactivity.

Several years later, the Navy again approached the medical center regarding the use of our facilities. This time their catheterization laboratory was going to be out of service for a scheduled renovation. As an interim measure they asked to use one of our special procedure radiographic rooms several days per week during the period of renovation.

The request was agreed to, but due to past difficulties with formal agreements, we offered use of the facilities as a humanitarian service and stipulated that the Navy provide their own supplies and personnel.

The following comments are based upon my observations at one location and I would have to defer to the VA Chief Medical Director as to the bill's effect on the agency as a whole.

In reviewing Senate bill S. 2958, it would appear that most, if not all of the past problems I have encountered under the Federal Economy Act, have been addressed and should be resolved by enactment of this bill. For example, as I interpret the bill, local officials are given authority to negotiate prices which are equitable and consistent.

I interpret this as meaning that we could waive reimbursement if costs were negligible or in terms of consistency, we could establish prices consistent with charges for the same services when provided by other community resources. We would not be burdened by the necessity of using approved interagency rates which appear to be based upon systemwide average costs. This provision would have made it possible to effectively share the VA's laser with the Navy.

The provision for reimbursement to the specific facility providing the service allows for support of direct operating expenses which could not otherwise be absorbed. This most certainly would have eliminated this medical center's primary difficulty in sharing cardiac catheterization facilities with the Navy. It also would offer a very tangible incentive to expand sharing of resources.

The local authority to establish operative sharing arrangements, subject to post approval, will not only be more responsive to the typically immediate needs of the medical community, but will also eliminate the local aggravation encountered in very lengthy precontract review and approval processes.

Often the interest of both parties to sharing arrangements has been significantly reduced by the time approval is obtained under current procedures.

By providing the authority to request supplemental funding and ceiling from Congress, an incentive is provided not only to share, but to share resources where capacity is not presently available and significant savings can be realized by both the provider and recipient through economies of volume.

Mr. Chairman, this is the end of my prepared statement covering experiences at the San Diego Veterans' Administration Medical Center, and I wish to thank you and the other members of your committee for having given me this opportunity to share my experiences.

Senator PERCY. Thank you very kindly. I think it has been extremely helpful to take a particular case here and follow it through as you have both been able to do.

Mr. Ahart, of GAO, mentioned the importance of the absence today of a legislatively established environment. Do you think that it is important not only that we in the legislation deal with the particular obstacles we face and that you found, but that we also establish an environment where the intent of the Congress, a bill signed by the President of the United States, is made eminently clear? That if the direction we are setting now, that we are directed to share and find ways to overcome those obstacles, is it important, in your judgment, that we have that legislative climate established?

Mr. YATES. From a strictly parochial standpoint, or regional standpoint, as Admiral Cox mentioned, yes, sir, very much so.

Senator PERCY. Admiral.

Admiral COX. Mr. Chairman, from a regional standpoint, I would say very definitely. I do have some concerns about what can happen with that double-edged sword from a central authority.

Senator PERCY. We will get into those to any extent you would like. How much are you currently spending on radiation therapy in the private community, and do you have any plans to acquire your own radiation therapy unit?

Mr. YATES. We are currently spending in the neighborhood of $250,000 per year for radiation therapy and we presently have a project in our 5-year plan for construction of a radiation therapy department at our medical center.

Senator PERCY. Do you have plans for other renovations in coming years, such as your cardiac catheterization laboratory that you mentioned?

Mr. YATES. We don't currently have plans in that area. However, our cardiac catheterization equipment is scheduled for replacement sometime in the next couple of years, I would say, based on its life expectancy. That doesn't necessarily mean we will replace it.

Senator PERCY. To the best of your knowledge, has there been any coordination between the local VA and Navy officials in the planning of Navy's $293 million hospital to determine what services could be provided to VA, such as radiation therapy?

Mr. **Yates**. I am not personally aware of any communication there.

Senator **Percy**. You have no knowledge of any communication or understanding?

Mr. **Yates**. No, I do not.

Senator **Percy**. Admiral Cox, did the Navy in planning its $293 million hospital in San Diego work with the VA to determine what services might be provided in the new hospital to save VA dollars currently being spent in the private sector?

Admiral Cox. The planning of the new facility has been ongoing for about 8 or 9 years. There were initial discussions with the Veterans' Administration but there has been so much shifting for site and sizing of the facility that there was not enough known definitely as to what the workload would be from our own immediate beneficiary population and to what excess capability there might be.

So there has not been direct communications on the specific details because we really thought it was premature.

Senator **Percy**. Do you suppose the failure of past attempts at sharing might have contributed to the situation where there hasn't been that effort made, and would S. 2958 have helped in that case?

Admiral Cox. I really don't think that the past experiences would preclude discussions, but certainly the passage of this legislation would encourage and give impetus to advanced planning discussions for sharing services such as that.

Senator **Percy**. Any further comments that either of you would like to make?

Mr. **Yates**. Not I.

Admiral Cox. No, sir.

Senator **Percy**. Thank you very much, indeed. We are most grateful to you. Based on your testimony then, we may want to submit some more questions to you for the record.

The next witness is Gen. Quinn H. Becker, former Chairman, Federal Health Resource Sharing Committee.

General Becker, we welcome you. I thank you very much for being here with us. Your testimony is not lengthy. If you want to summarize it, you can, or give it in full.

TESTIMONY OF BRIG. GEN. QUINN H. BECKER, M.C., SUPERINTENDENT, U.S. ARMY ACADEMY OF HEALTH SCIENCES, DEPARTMENT OF THE ARMY

General **Becker**. Mr. Chairman, I would like to read my short statement. I believe it will help us understand the Federal Health Resources Sharing Committee a little bit.

I am Brig. Gen. Quinn H. Becker, Superintendent of the U.S. Army Academy of Health Sciences in Fort Sam Houston, Tex. I was the chairman of the Federal Health Resources Sharing Committee from October 1, 1979 to June 13, 1980.

It is my privilege today to provide you with a brief overview of this organization. In addition, I would like to describe those obstacles to sharing experienced by this organization and comment on the impact on Federal health sharing of Senate bill 2958.

The Federal Health Resource Sharing Committee was formed in 1978. The organization consists of representatives from the Veterans' Administration, the Public Health Service, the Department of Defense, and the Army, Navy, and Air Force. The Committee is chartered to identify and promote opportunities for joint planning and use of health care resources of the member agencies. Meetings are held bimonthly with the chairmanship rotating annually between agencies.

The Federal Health Resource Sharing Committee operates through functional subcommittees. These subcommittees have been chartered to recommend planning guidelines and specific sharing opportunities in specialized, high-cost areas such as computed tomography, cardiac catheterization laboratories and medical information systems.

The members of these subcommittees represent the clinical and professional expertise of each member agency. The subcommittee recommendations, upon approval of the full committee, are forwarded to the member agencies for consideration.

In January of this year, a subcommittee was formed to confirm the General Accounting Office findings and to develop recommendations which would facilitate the removal of fiscal and policy obstacles to interagency sharing. This subcommittee has identified the primary impediments to health sharing as: Incompatible reimbursement methodologies; insufficient local authority in negotiating sharing agreements; and the lack of legal authority to treat beneficiaries of other Federal agencies. Midway through the subcommittee deliberations, Senate bill 2958 was introduced.

The subcommittee has conducted an indepth analysis of the bill. Many of their recommendations have been incorporated in the subsequent version of the bill.

Enactment of this bill will remove the sharing impediments I have enumerated. In addition, it would provide incentives for Commanders and Directors of Federal health facilities to enter into health sharing arrangements with other Federal providers. Health sharing and the planning for health sharing can become common activities within the Federal health community.

That is the end of my prepared statement, Mr. Chairman. I am ready for your questions.

Senator PERCY. I think one of the most important aspects of your testimony, which you didn't emphasize very much, is the fact that you did make a thorough analysis of the previous legislation that we introduced and made strong recommendations which we tried to incorporate in the new version, S. 2958, in the best tradition of a good piece of legislation. We tried to work this out. The services would have to carry it out. They can really feel they have had an impact on it. I think rather than the Congress sitting here in a vacuum, legislating and then directing that this be done, I have always felt we will do a lot better job if we really give you an opportunity to have your input and that has been done in this case, and we very much appreciate what you have already accomplished in improving the legislation.

I understand that you and your staff were involved with the attempts in Boston to share services between the Army and the VA. Could you describe what were the potential benefits of an agreement there, that is to the Army and to the Federal Government? What obstacles held up your progress and how S. 2958 might have been helpful to you.

General **Becker**. Yes, sir. The U.S. Army was forced to discontinue orthopedic in-patient services at Fort Devens, Mass., in June of this year. This decision was brought about by a shortage of orthopedic surgeons in the Army. Preliminary discussions between the Commander of Cutler Army Hospital at Fort Devens and Chief of Medical Services, VA, Boston, identified a limited amount of excess orthopedic capability at the VA facility.

In addition, it was determined that moving a negotiated sharing agreement under the VA sharing law would allow reimbursement to be used for personnel salaries, thereby increasing the VA in-patient capability. Our attempts to negotiate was blocked by the differences in the law governing the operation of the Department of Defense and Veterans' Administration.

This also demonstrated the need to give local facility officials increased authority and have reimbursements returned to the providing facilities' current program. The difficulty we experienced reflects the major obstacles to sharing Senate bill 2958 would remove.

Also, out-patient services were involved in this. As we proceed along to attempt to come to an agreement on it, the obstacles in the titles that we both operate under just became insurmountable. Did that answer your question, sir?

Senator **Percy**. Yes, sir; it does. I wonder specifically if you believe that the concerns expressed in your legislative subcommittee regarding the need to eliminate obstacles and create proper incentives and mechanisms for sharing are adequately expressed in 2958? Have you had any additional thoughts because we still can improve it, still modify it. That is the purpose of this hearing.

General **Becker**. Yes, I believe the obstacles can be overcome by the legislation. Incidentally, a unique aspect of the development of the legislation was that our subcommittee, as you mentioned, was allowed to comment on the bill freely, and also we worked very closely with the GAO. That doesn't happen too often either. I think that was a unique experience for us. As you said, there was cooperation amongst people from the legislative and the Defense Department and the GAO.

I think there are some minor concerns about the bill. I am not in a position now in my present capacity to comment on them. I think they will be brought up by the heads of the Army, Navy and Air Force Medical Services.

Senator **Percy**. I want to comment on your own comment on working with GAO. I hope the Corps of Engineers are listening. I have on occasion asked GAO to study projects the Corps of Engineers has been doing, particularly in Illinois. We have another one we are looking at that affects the States of Tennessee and other States. It is a pretty big project, a $3 billion project. We found an $11 billion project in Chicago that we are looking at. GAO has really shaken everything up, caused us to all rethink whether that procedure is the right procedure and your own favorable working relationship with them I hope will set a good precedent. We have a lot of room ahead.

General **Becker**. Yes, sir.

Senator **Percy**. Finally, what new sharing arrangements between DOD and VA have been entered into since the creation of the Federal Health Resources Sharing Committee since February of 1978?

General **Becker**. Sir, early on, there was a problem in Augusta between the local community there and our facility, Dwight David Eisenhower, with the cancer treatment facility there, and we did decline to open a cancer treatment facility there which would have required expensive equipment and two very highly skilled physicians. That was accomplished. Now there is the closure of the Cardiac Catheterization Laboratory in Dayton, Ohio, with the Veterans' Administration and a possible closure of the Cardiac Catheterization Laboratory here in Washington at Andrews Air Force Base.

In addition to that, I think one of the great benefits of this committee has been that we have been together and there has not been a proliferation of expensive health care modalities if you will, because they know that we were all watching this and that it can't be enumerated because we don't know how many of these starts would have culminated in excess services because they were never started.

And I think probably that was the greater benefit of our committee. It was the first time the five Federal health services had really sat down together and officially worked together for long periods of time on complex problems.

Senator **Percy**. General Becker, I thank you. You are very encouraging. We are pleased to have your testimony.

Our fourth panel consists of John Moxley, Assistant Secretary of Defense for Health Affairs. He will be joined by Vice Adm. W. P. Arentzen, Surgeon General of the U.S. Navy, Lt. Gen. Charles Pixley, Surgeon General, U.S. Army, Lt. Gen. P. W. Myers, Surgeon General of the U.S. Air Force.

Dr. Moxley, please go right ahead. You have a prepared statement. You can summarize it or do it in any way you see fit. The entire text will be incorporated.

TESTIMONY OF JOHN MOXLEY III, M.D., ASSISTANT SECRETARY OF DEFENSE FOR HEALTH AFFAIRS, ACCOMPANIED BY VICE ADM. W. P. ARENTZEN, SURGEON GENERAL, U.S. NAVY; LT. GEN. CHARLES C. PIXLEY, SURGEON GENERAL, U.S. ARMY; AND LT. GEN. PAUL W. MYERS, SURGEON GENERAL, U.S. AIR FORCE

Dr. **Moxley**. With your permission, Mr. Chairman, it is a short statement. I am John Moxley, Assistant Secretary of Defense for Health Affairs.

I have been designated to represent the Secretary of Defense in connection with these hearings and would like to express my appreciation for the opportunity to appear before you today.

During my brief tenure in DOD, approaching a year now, I have been impressed that the needs and requirements for military health services greatly exceed our available resources. This is true whether one is addressing either a wartime or a peacetime scenario. This comes as no surprise, really, for the same is equally true in the civilian medical world. The need to come to grips with a major contributor to this problem—which is rapidly rising expenditures for medical care—was recognized by the enactment of legislation creating the Professional Standards Review Organizations and the Health Systems Agencies.

While neither of these laws applies directly to DOD, we nevertheless have attempted to utilize some of their recommendations in planning our own activities. The peer review concept has been completely implemented within DOD. Our efforts to maximize the utility of our resources has taken two forms. The first effort, which has been mentioned this morning, one we are vigorously pursuing at the present time, has to do with contingency preparedness—to care for our combat wounded.

In previous conflicts, the care of war casualties has taken place entirely within military medical facilities. While we would much prefer to be able to continue this tradition of "taking care of our own," it is clearly no longer feasible to do so.

Accordingly, we are working closely with both the Veterans' Administration and various civilian medical authorities to create sharing agreements whereby VA and civilian medical facilities and staffs will be prepared to receive and treat casualties when their number exceeds our in-house capability, which in some scenarios could be very early on indeed.

We believe this approach has the potential to solve one of our most pressing problems and, I might add, we are particularly gratified by the enthusiasm and cooperation we have received, not only from the Veterans' Administration, but also civilian officials and organizations such as the American Hospital Association and the American Medical Association.

A second effort toward sharing which is being addressed is that involving our day-to-day operations. As you have heard, 2½ years ago, the senior medical officials of DOD, the VA, the Public Health Service and the Military Departments created the Federal Health Resources Sharing Committee, FHRSC, to specifically promote this kind of sharing. Through this effort we made three major discoveries:

One, driven by necessity and convenience, a substantial amount of sharing already goes on in a wide variety of ways.

As FHRSC has addressed sharing in areas of high-cost technology, we have found—as have others—that it is far from easy; and it is by no means clear which of the many approaches to sharing will be most fruitful, let alone successful.

Finally, there are many legislative and administrative barriers, the removal of which would facilitate more broadbased sharing.

The legislation proposed in S. 2958 would aid in removing the impediments referred to above; accordingly, the Department of Defense favors its enactment. We are convinced that the widest possible sharing among Federal health care providers will benefit us all.

This concludes my prepared statement, Mr. Chairman. I shall be pleased to answer any questions you may have regarding this matter or any other aspects of the military health care system.

Senator **Percy**. Dr. Arentzen, I understand you have a prepared statement. The entire text of it will be incorporated in the record. I understand this is your last day of service. You are retiring tomorrow?

Admiral **Arentzen**. Tomorrow I will be relieved by Rear Adm. J. William Cox.

Senator **Percy**. We will try to not make this an unpleasant experience for you. We congratulate you very much indeed for your distinguished service.

Admiral **Arentzen**. Mr. Chairman, I am Vice Adm. Willard P. Arentzen, Medical Corps, U.S. Navy, Surgeon General of the Navy.

I am pleased to be here today to discuss Federal health resource sharing. This issue is of increasing importance in our resource-scarce economy—and it is an area in which, I am proud to say, the Navy has continually progressed.

The bill, S. 2613, reflected a strong commitment to broaden the entire scope of health resource sharing throughout the entire Federal health care system.

This commitment, growing largely from economic and technological pressures, offers an extremely attractive option within the Federal health care system. In addition, Federal sharing promotes increased access and availability of care, supporting our benefit mission and contributing to the satisfaction of the Navy family.

The recently revised bill, S. 2958, before committee today, is narrower in its participants because it does not include the Public Health Service with whom we have a variety of sharing arrangements. Although this bill is a step toward a more responsive Federal sharing program between the VA and DOD and represents the development of a positive and progressive legislative initiative, we nevertheless feel that the Public Health Service must be included. I find it difficult to support this bill without the incorporation of Public Health Service, and other Federal agencies.

The Navy Medical Department, a worldwide health care delivery system, participates in numerous sharing arrangements with Department of Defense activities, Public Health Service, other Federal agencies, local governments, and civilian institutions.

Resource sharing within the three medical systems of the Department of Defense exist in areas such as drug screening laboratories, cross servicing of in-patients and out-patients, veterinary medicine, clinical laboratory, radiology and optometry, and cardiac catheterization, just to name a few.

Services such as out-patient clinics, industrial hygiene, and radiology are shared with and/or provided for Public Health Service and Coast Guard.

In addition to the many sharing programs with Public Health Service, Navy is involved in various sharing arrangements with VA, in areas such as CT scans, radiation therapy, emergency services, and various other specialty services.

I believe, as I know you do, that we must pursue every opportunity to increase the efficiency and effectiveness of our operations through optimal utilization of available resources. One such effort to expand Federal health resource sharing concerns the potential for increased sharing between the Naval Regional Medical Center, Great Lakes and the North Chicago Veterans' Administration Hospital.

Let me take a minute to provide you with some background on our Regional Medical Center at Great Lakes.

The Naval Regional Medical Center at Great Lakes is a general medical/surgical acute care hospital which has been in continuous operation since October 1911. The main hospital building in use at this time was opened in December 1960 and was built at a cost of $16 million. Its replacement cost is estimated at $220-plus million. Present capacity is 656 beds.

Nine wards are open with an in-patient capacity of 190. Thirteen wards are closed with a potential additional capacity of 466 beds. Clinics in operation include: General surgery, urology, internal medicine, cardiology, general medicine, pediatrics, orthopedics, dermatology, psychiatry, obstetrics and gynecology, opthalmology, podiatry, physical therapy, radiation therapy and nuclear medicine.

Major satellite activities are located at the Naval Air Station, Glenview, Ill., the Naval Air Facility at Detroit, the Recruit Training Center, and the Naval Training Center at Great Lakes.

The primary mission of the Regional Medical Center is to provide medical care for approximately 20,000 active duty members located at the Naval Recruit Training Center, the Naval Training Center and other commands in the area such as those at Fort Sheridan. In addition, as resources allow, we provide care for over 62,000 other eligible beneficiaries. A surgical platoon cadre and its supply block are kept manned and ready at all times. The entire military staff is a trained cadre of medical personnel who are immediately available for deployment in support of the U.S. Marine Corps, fleet hospitals and other forward combat operations as current war plans dictate.

More than 7,000 patients are admitted for treatment each year. The average daily patient load is about 120 patients. Of the 350,000 out-patient visits yearly, about 178,000 are treated in the main hospital clinics with the remainder receiving care in our outlying clinics.

This workload is supported by a staff of approximately 900. Of these only 34 are military physicians. Although the population supported has remained relatively stable, the number of military physicians has decreased from 80 in 1976 to a total of 34 today.

Great Lakes is not unique in experiencing such a physician drawdown. Shortages have existed throughout the Navy system since the end of the draft.

An indicator of the impact of this shortage is the increase in patients receiving in-patient care under the civilian health and medical program of the uniformed services, or CHAMPUS. In fiscal year 1976 Great Lakes referred 165 patients under the CHAMPUS program. By fiscal year 1979 this had increased to 1,040—obstetrics and pediatrics and psychiatry referrals accounted for 80 percent of this 1,040. In a recent 12-month period, the Government cost for CHAMPUS in-patient care in the Great Lakes region was $1.5 million. Out-patient CHAMPUS cost amounted to approximately $300,000 during the same period.

To alleviate our dependence upon the CHAMPUS program and make fuller use of our facility, we are exploring the feasibility of a major sharing arrangement with the Veterans' Administration. Under this arrangement, the Navy would gain the services of VA physicians and various ancillary support staff which would enable NRMC Great Lakes to bring some of the CHAMPUS workload back in-house.

In return, the plan calls for the integration of approximately 250 to 300 acute care medical and surgical VA patients within the Regional Medical Center, Great Lakes.

This proposed arrangement is a significant expansion over the sharing agreements currently existing between the two hospitals.

The Veterans' Administration Medical Center, North Chicago currently provides the Naval Regional Medical Center with the services of a radiation therapist. In return we provide the cobalt equipment and ancillary personnel necessary to operate a radiation therapy department, and patients from both medical centers are treated at the naval hospital. There is no reimbursement.

Adequate clinical experience for either the VA general practice residency in dentistry or the naval oral and maxillofacial surgical residency program were not available solely within the sponsoring institution. An agreement was reached with the Veterans' Administration Medical Center so that residents can obtain clinical experience at both facilities. There is no reimbursement.

In addition, the Veterans' Administration Medical Center, North Chicago, provides the services of cardiologists to operate a cardiology department at the naval nospital. In return the Naval Regional Medical Center provides blood products to the Veterans' Administration Medical Center. There is no reimbursement. This arrangement has been approved by BUMED and is awaiting approval by the Veterans' Administration.

Should an in-patient sharing arrangement of the magnitude proposed prove feasible, the potential benefits to the Navy would include:

Expansion of services for the beneficiary population; increased accessibility to care; availability of a portion of the medical staff which would remain in place under mobilization; more efficient utilization of our facility; and a cost savings to the Government and the Navy beneficiary.

It would be premature to discuss specific scenarios for the sharing agreement that is under consideration for the two institutions.

For example, characteristics of the Veterans' Administration beneficiaries such as age and types of illnesses encountered differ considerably from the average Navy patient. The impact of these differences on patient care requirements will have to be carefully assessed during our review in order to estimate the numbers of Veterans' Administration beneficiaries that could be accommodated with the existing support staff and the staff augmentation which would be required from the VA.

The key to success is early and thorough planning, done with an awareness of the future. Today's decisions should allow the kind of development that will be desirable tomorrow. It is important to project the expected results of sharing alternatives. This is desirable so that each alternative—including a continuation of the present system and any contingency situation—may be identified in the feasibility study.

The Federal Health Resource Sharing Committee, called the FHRSC, is instrumental in identifying sharing opportunities and it also encourages greater interagency coordination. As part of their progress in this arena, the FHRSC's legislation subcommittee has reviewed the patchwork of statutes and administrative practices which govern interagency sharing.

As evidenced by the significant number of agreements in effect, legislation does not preclude resource sharing. In fact, title 31, U.S.C., section 686—The Economy Act—provides a broad base for interagency sharing. However, the impact of subsequent laws, and various agency guidelines, have reduced the flexibility of Federal agencies in pursuing sharing opportunities.

I am pleased to see that the proposed legislation under consideration today clearly emphasizes the intent of the Congress to encourage sharing. This broad policy statement will facilitate removal of several administrative obstacles and provide a base from which to work for increased interagency health resource sharing as appropriate. Again, I must reemphasize the need for Public Health Service to be included if Navy is to support the bill.

The challenge is formidable. The care we provide must be of the highest quality and cost-effective. Navy medicine—indeed, all military medicine, public health, and VA—must exercise leadership in anticipating and providing for the future health care needs of our beneficiaries in all areas of endeavor including increased development of sharing arrangements.

I appreciate the opportunity to be here today and I stand ready to respond to your questions.

Senator PERCY. As a retirement gift from the Senate, I will make at least what we call a best effort to find a role that Public Health Service can play in the committee work. We certainly take your counsel to heart and will see if we can work out something on that.

I would like to comment on your statement, where you said that the main hospital building at Great Lakes, which I know reasonably well, cost, in 1960, $16 million, and its replacement cost is estimated at $220 million. In 20 years, that would be 1,400 percent inflation—is that just in building costs? I am not familiar with a comparable inflation rate in even home construction, though it has been a great deal.

Admiral ARENTZEN. These figures were given to me by my facilities division.

Senator PERCY. That is staggering.

Admiral ARENTZEN. Yes, sir.

Senator PERCY. No wonder why the Defense establishment costs us a lot of money. With what inflation in the domestic economy is doing to our ability to adequately provide funds for new weapons systems, personnel, everything else, there has got to be a very high order of priority.

I would like to ask you also, you mention though your primary concern is with 20,000 active duty members located in the Naval Recruiting Training Center, the Naval Training Center and other commands, as resources allow, you say, "we provide care for over 62,000 other eligible beneficiaries."

Could you describe what those responsibilities are the Navy holds for 62,000 people, who are they, what categories are they in, what eligibility? What is your own personal feeling as to whether there is any abuse, whether the legislation is just simply too extensive and expensive, let's say, based on your own long experience.

Admiral **Arentzen**. Our primary mission, Mr. Chairman, is to take care of active duty personnel and have them ready for any contingency. We are not funded, and we are not staffed to take care of the peacetime health benefit mission. So the retired and their dependents and the active duty dependents are treated on a space available basis. Unfortunately, at Great Lakes we no longer have the staff there to take care of all these individuals. Therefore, we are directing more patients to the civilian sector on CHAMPUS, which costs the taxpayers more money. It also costs the sailor much more money out of his own pocket. It is less expensive to treat them in our own hospitals. I think if we can get this arrangement with the VA, we are not only going to save Uncle Sam money but also our beneficiaries.

Senator **Percy**. General Pixley and General Myers, you do not have prepared statements, as I understand it. Would you agree, however, with Dr. Moxley's comments regarding the need for legislation to remove legislative and administrative barriers to facilitate more sharing and would you care to make any comments on that?

General **Pixley**. Yes, sir, I would like to correct for the record, I have, for the Army, a prepared statement which I would like to submit into the record.

Senator **Percy**. Fine, it will be incorporated in full in the record following your testimony.

General **Pixley**. With regard to your question, sir, I would certainly endorse all of the comments by Admiral Arentzen. I also believe it would be helpful if the Public Health Service were included in the new legislation.

Senator **Percy**. Fine. Thank you.

General **Myers**. Mr. Chairman, I have also a prepared statement that I would submit for the record.

Senator **Percy**. It will also be incorporated in the record.

General **Myers**. I would like to also state that we certainly support, from the Air Force point of view, the pending legislation, and a personal comment, if permitted.

As a longtime practicing specialist and medical center commander and now Surgeon General, for more than 25 years I have had an opportunity to watch sharing.

I recall your statement that what has worked has worked well. I would like to emphasize that. There is more going on than perhaps meets the eye. A good example is the $97.5 million project to modernize and expand the Wilford Hall Complex, which is our major medical center in San Antonio, where the Army, Navy, Veterans' Administration, all were included in that renovation.

Your bill will certainly encourage further sharing, but I think I would be remiss if I didn't raise two important considerations. One of these is that the determination of costs at the local level will become much more easy when the uniform chart of accounts comes into effect in the next year or so. There are congressionally imposed manpower ceilings which do place limitations on the sharing of services especially if those services need to be expanded by the use of more technicians. Thank you very much.

Senator **Percy**. Thank you. Dr. Arentzen, I would like to ask you a question and then possibly General Myers and General Pixley could comment at least on the last phase of it. How would S. 2958 encourage and enable sharing arrangements, such as the opportunity at Great Lakes, and also how would the Navy and Federal Government benefit from these cross-agency arrangements?

Admiral **Arentzen**. I think the main advantage, Mr. Chairman, would be the benefits to all of our beneficiaries—our sailors, and their dependents as well as retired and their dependents. We just can't take care of all of them at the present time. With the VA arrangement, we will have the capability of expanding care. It will provide increased accessibility of care to our people, care which is not available to them now unless they go out and pay for it on their own on CHAMPUS. We would like to see our wards filled up. We don't like to have all these wards go empty. For the building alone, we will have to spend approximately $1 million to change the wainscotings, because it doesn't meet the standards of the Joint Commission on Accreditation of Hospitals. This arrangement can be a big saving to our Government, Mr. Chairman.

Senator **Percy**. Any comments, General Pixley?

General **Pixley**. Yes, sir, I would like to add this observation that I think in many areas where there are Army facilities today, also nearby Veterans' Administration facilities, it is much more convenient for the soldier if he can be locally placed to avoid long distance evacuation to tertiary care centers.

Many times we are providing care for the active duty with supplemental care which means we go out and buy the service in the local community. That is much more expensive than using other Federal facilities.

Senator **Percy**. General Myers.

General **Myers**. In way of amplification, Mr. Chairman, the two driving factors are certainly patient convenience and the key, as Admiral Arentzen has said, is accessibility and cost benefit. Certainly sharing will provide for both. Health care delivery by military treatment facilities in the health care system is cheaper and at times more effective than it is in the civilian community.

The No. 1 responsibility we have is to provide accessibility and convenience to our beneficiaries. We can do that better with this proposal.

Senator **Percy**. Dr. Arentzen, if the Public Health Service were given a role in the Interagency Committee established in S. 2958, could we then count upon your own support and the Navy's support?

Admiral **Arentzen**. Yes, sir; Mr. Chairman. Public Health Service is definitely needed because we have so many sharing agreements with them. We just signed a memorandum with the National Institute of Health to share an oncology service. Other examples include the use of the Public Health Service Hospital at Norfolk; sharing arrangements in various clinics at San Diego, outpatient clinics at Yorktown, and the Public Health Service Hospital at New Orleans.

We also have sharing arrangements with the Indian Health Service. They are staffed by Public Health Service physicians but belong to the Department of Interior. We provide optometry and otolaryngology services to them.

Another example is the Coast Guard, which belongs to the Department of Transportation and is staffed by Public Health Service physicians. In New London we have a relatively new hospital, about 6 or 8 years old. Five minutes away the Coast Guard has a hospital which is antiquated. Although some people in the Coast Guard would like to use our nearby medical facility there is movement afoot to build a new hospital over there. They also have four surgeons and I am short of surgeons. They normally have eight inpatients daily. We could absorb their entire workload if need be. At Long Beach, surgical and orthopedic clinics are held at our hospital by the Coast Guard physicians. Similarly, we provide service to the Coast Guard in the Oakland area. I would strongly support the bill but I think the Public Health Service has to be included, Mr. Chairman.

[The prepared statements of General Pixley and General Myers follow:]

PREPARED STATEMENT OF LT. GENERAL CHARLES C. PIXLEY

Mr. Chairman and members of the Committee. I am Lieutenant General Charles C. Pixley, The Surgeon General, Department of the Army. It is my privilege today to provide you with comments on the impact on the Army Medical Department of Senate Bill 2958.

The Army Medical Department provides Health Services to support Army Readiness Requirements. Involved are preventive and curative medical, dental and veterinary services for the Army in the Continental United States, in other areas where the Army is deployed, and as directed by the Secretary of the Army.

The objectives of the Army Medical Department are to: 1) maintain a physically and mentally fit, combat and operationally ready military force; 2) ensure timely availability of trained health manpower and other health resources required for support of approved combat, mobilization, and contingency plans; 3) provide a proper program of health services for all eligible beneficiaries; 4) maintain a challenging environment which attracts and retains health professionals; and 5) assure effective, efficient, and complete utilization of Army health resources.

The Army has for a number of years recognized the increasing costs associated with meeting Medical Department objectives and the role Federal health sharing has in holding down these costs.

We have strongly supported the creation and activities of the Federal Health Resource Sharing Committee. In consonance with this Committee's recommendation on cardiac catheterization laboratories, Walter Reed Army Medical Center has taken action to accommodate the Air Force workload from Malcom Grow Medical Center at Andrews Air Force Base. The Army has halted action to initiate a cancer treatment service at Dwight David Eisenhower Army Medical Center. The decision was based on a Federal Health Resources Sharing Committee recommendation that excess capability existed in the local community.

Our sharing programs with other Federal agencies extend beyond direct patient care. This year the Army Medical Department has programmed 1,156 enrollment allocations for Air Force, Public Health Service, Veterans Administration and civilian health care providers to attend post graduate short courses offered in Army facilities.

The US Army Health Services Command, headquarters for Army medical treatment facilities in the United States, has 142 formal agreements in effect with other Federal agencies for providing and receiving health related services.

Current law which controls provision of Federal health services, limits an increase in health service sharing among Federal providers. The primary difference in these statutes is the prescribed manner in which reimbursement for shared health services are managed in each agency.

An example of the problems encountered has been the recent effort to establish a sharing agreement for orthopedic services between Cutler Army Community Hospital at Fort Devens, Massachusetts and Veterans Administration Medical Center, Boston. The issue has not been resolved due to our inability to arrive at an appropriate reimbursement rate and methodology, and still remain within the bounds of our respective statutes.

The proposed legislation would create an environment in which medical facility commanders can have additional health service alternatives available for the care of the population they serve. This environment will enhance the quality and accessability of care to the patient and has the potential to do so at a decreased cost to the Federal Government.

I support this sharing concept embodied in Senate Bill 2958 and urge its favorable consideration by the Committee.

PREPARED STATEMENT OF LT. GENERAL PAUL W. MYERS

Mr. Chairman and Members of the Committee:

I am Lieutenant General Paul W. Myers, Surgeon General, United States Air Force. I appreciate the opportunity to appear before you today to discuss the sharing of health care resources.

The Air Force Medical Service endorses, promotes, and actively participates in the sharing of health care resources among the Federal agencies. The primary consideration in determining the extent of sharing by the Medical Service is wartime contingency support and the availability of medical resources. At the present time, these factors place limitations on the scope of the projects which can be implemented. Nevertheless, the Air Force Medical Service participates in a variety of interagency sharing arrangements. Results of a recent Federal sharing survey showed that more than half (67) of our medical facilities were involved in some type of medical services sharing during FY 1979. Most sharing is clinical in nature at the local level with the Army and Navy. Twelve of our facilities reported sharing with Veterans Administration (VA) hospitals and eight others shared with Public Health Service hospitals. The total value of services exchanged between the Air Force and other Federal medical institutions for FY 1979 is estimated to be $19.6 million.

Following are examples of the types of services provided:

Several USAF CONUS and overseas medical facilities provide VA eligible patients outpatient support. The hospitals at Elmendorf AFB, Alaska and Minot AFB, North Dakota, have designated VA beds and provide VA beneficiaries inpatient and outpatient care. All the services at Minot are also available to the Public Health Service.

The USAF Medical Center, Keesler AFB, Mississippi, rotates surgical residents through the Biloxi VA Hospital plus providing nuclear medicine and radiation therapy support. The USAF Medical Center, Wright-Patterson AFB, Ohio, provides radiation therapy and diagnostic cat scans for VA patients. Wright-Patterson and VA provide cooperative inpatient care in each hospital. The VA provides laboratory and special study support to Hill AFB, Utah, and Ellsworth AFB, South Dakota.

The Air Force blood program and Air Force medical facilities provide the VA whole blood on an emergency basis. This service is reciprocated at the local level.

A major sharing program is the aeromedical evacuation of patients. The USAF Aeromedical Evacuation System has the unique mission of providing rapid air transportation for sick, injured and wounded active duty military members. Other DOD beneficiaries, as well as VA and Public Health Service patients are transported when not in conflict with primary mission support.

Another special service that we share with other Federal agencies is the hyperbaric medicine chamber at the USAF School of Aerospace Medicine, Brooks AFB, Texas. We maintain a 24-hour chamber crew and physician coverage for the life saving emergency treatment of patients with carbon monoxide poisoning, gas gangrene, and decompression sickness. The physician staff acts as consultants in diving medicine, aerospace medicine, and hyperbaric medicine to numerous Federal agencies, and they perform research in the areas of wound healing, radiation injury and spinal cord injury.

These examples of shared services reflect our concern for quality health care and effective utilization of resources. In addition, we have actively supported the efforts of the Federal Health Resources Sharing Committee. In accordance with the desires of this committee, we will be closing our cardiac catheterization laboratory at Malcolm Grow USAF Medical Center by December 1980 and transferring the workload to military medical centers in the Washington, D.C. area. In keeping with a similar committee proposal, the medical center at Wright-Patterson AFB, Ohio, is prepared to assume by this September, the cardiac catheterization workload at the Dayton Veterans Administration Center.

In keeping with plans for major contingencies, the Air Force is actively working with the Department of Defense in developing a civilian-military contingency hospital system. The USAF Medical Center at Scott AFB, Illinois, has been designated as the initial area for local implementation of this concept.

During the past year, the Air Force initiated the first tri-Service medical wartime training program. Since November, we have held two Medical Red Flag exercises to train physicians and other health professionals in battlefield medicine. In addition to Air Force personnel, Army, Navy, VA and civilian disaster preparedness officials participated in these exercises. We currently are planning to expand tri-Service cooperation in wartime training.

Because of the wartime mission requirements of the military services, the sharing of specific resources should not be mandated. There are numerous provisions in law which authorize the sharing of health resources among Federal agencies. There are also some restrictions. For example, within the Department of Defense, 10 U.S. Code (Section 1071-1076) limits care to only authorized beneficiaries. Further, Congressionally imposed manpower ceilings limit expansion of services for sharing. For the Veterans Administration, 38 U.S. Code (Section 5051-5053) restricts sharing to specialized medical resources which are either unique in the medical community or are subject to maximum utulization only through mutual use. For the Public Health Service, 42 U.S. Code (Section 254a) specifies that only specialized medical resources may be shared.

The proposed legislation is designed to encourage and assist in the expansion of sharing arrangements while preserving the separate mission and primary beneficiaries of each agency concerned. We support the principles underlying this initiative.

I will be happy to answer any questions you may have.

Senator PERCY. Yes, Dr. Moxley.

Dr. MOXLEY. Mr. Chairman, if I might, let me comment in two areas, and once again I make those comments in the most constructive sense. I think this bill is a step forward. As I have already stated, I support it.

I think, however, I would be remiss not to comment at least briefly on the complexity of the overall situation that we are addressing. In that regard, let me momentarily put on my former hat, which is vice chancellor for health sciences, University of California, San Diego, where I was involved with both the San Diego VA and the Naval Regional Medical Center in San Diego.

First of all, there was rarely a week, and never a month, that went by that I wasn't in direct communication with the commanding officer at the Naval Regional Medical Center and director of the VA hospital. There was a very good and productive relationship. As a matter of fact, a number of sharing agreements were developed. Interestingly, those sharing agreements dealt almost exclusively with integration of staff and with educational projects, the reason being that we very quickly ran into all sorts of barriers that your bill is trying to remove when we began to talk about patient care.

It was very complicated, but not because there wasn't a constructive environment. We were all working fruitfully together in other areas, but when it came to services, be it laboratory services, radiation therapy, so forth, it became a much more complex situation because we had three bureaucracies that had to be deal with—the University of California, the Veterans' Administration, and the Department of the Navy and the Defense Department.

Second, a comment that ideas can sound good, look good on paper but become very complex when you try to implement it. Let me focus for a moment on radiation therapy. I am an oncologist and had some experience in this area. It looks very easy to say we ought to have patients go some place for radiation therapy. The fact of the matter is most of those patients are, in fact, very ill. Although they do qualify as being ambulatory when they get their therapy, there are a lot of side effects as a result of the treatment. Transporting them around for therapy is in fact very complicated.

In my judgment, therefore, it is important to look at both sides of the coin, not just being able to consolidate radiation therapy equipment, which is expensive, but to program into the facilities, as they are developed, a capability of caring for the extra patients that are going to be using that equipment. I do not believe it is in the best interest of patients to transport them on a daily basis back and forth between facilities. I think it is essential that if one Federal hospital in an area is going to have radiation therapy and service other hospitals that the inpatient capability be programed so that those patients do not have to be transferred. Thank you very much.

Senator PERCY. One last question, Dr. Moxley. What, in your judgment, are the potential benefits to your beneficiaries, the Defense Department, and the Federal Government, and the kind of broad-based sharing that you have referred to in your statement today being possible with the enactment of S. 2958?

Dr. MOXLEY. I think, as I indicated, although it is going to be difficult and complex, I think we can all come out of it with stronger and better services for our beneficiaries. I think this can be accomplished without threatening the basic integrity of the several systems that are involved. I think that those are going to be the primary benefits. As Admiral Arentzen has said, it is going to be to the benefit of our beneficiaries. I think that there are two very importants element in the bill. One is obviously to reduce the legislative and other sorts of administrative roadblocks and, as I have indicated, they are significant. But, second, and most importantly, in my judgment, is to build in incentives at the local level to share. I think that applies not only to Federal hospitals and health care systems, but I think it applies also to the civilian sector. If that incentive is built in at the local level for the sharing to occur, I think there will be a lot more of it, and I think we will all be more better off.

Senator Percy. Thank you. I have a couple of additional questions I would rather ask for the record only. The first pertains to the Congressional Conference Report for Fiscal Year 1977, where DOD was instructed to develop policies making maximum cost-effective use of existing hospital assets. I would like to give you an opportunity to show what progress has been made since that date.

And the last question indicating, because GAO indicated to us, certain alternate methods of providing care to DOD beneficiaries were possibly resorted to because the individual DOD hospital comnanders would not have to pay for such services out of their own hospital budgets. I would like to find out what has been done to correct this particular situation since it was pointed out by GAO. I think that would require a little bit of research on your part and I will not take the time this morning then. I want to thank all of your very much indeed for your appearance today and great help.

[Responses to questions follow:]

Responses to Questions From Senator Percy by DOD

Question 1, Part 1. What are the current plans and estimated costs for the Army, Navy and Air Force in fiscal year 1981 through fiscal year 1984 to (a) build new hospitals and clinics or (b) renovate and modernize existing facilities?

Answer. Attached is a list of those projects included in the President's Budget for fiscal year 1981. Also attached are planned military construction projects for fiscal year 1982 through fiscal year 1984. Each entry indicates the purpose of the project, i.e., replacement, addition, alteration, etc.

Part 2. Question. In the Congressional conference report for fiscal year 1977 DoD military construction, DoD was instructed to develop policies which would enable it to make maximum and cost-effective use of existing hospital assets, be they DoD, VA Public Health or civilian hospitals. Can you cite examples where DoD has been successful in building hospitals of a somewhat smaller basis because you used existing hospital assets of a VA, Public Health or civilian hospital?

Answer. We cannot cite specific examples since fiscal year 1977 of reduced DoD hospital construction size because of the utilization of existing hospital assets of a VA, Public Health or civilian hospital. However, there are numerous examples where DoD has accommodated. VA requirements in existing facilities or new construction. A current example of this is the construction project for Tripler Army Medical Center in Hawaii. The new facility will include 65 beds for the VA, an increase of 20 beds over the current number. In fact, in fiscal year 1979 there were 166 beds in 17 DoD hospitals that were maintained for VA patients.

There are examples of this kind of sharing that go back prior to 1977. In the 1960's, the Air Force took over the operation of a VA hospital at Minot, North Dakota and continues to set aside beds for VA and PHS patients. VA/PHS beds are part of the planned replacement of this facility in fiscal year 1983. The VA was planning to build a hospital in El Paso but changed those plans when DoD agreed to include VA beds in the William Beaumont hospital construction project (1969-72).

While the DoD and the PHS do not designate a specific number of beds for each others beneficiaries, they are routinely accommodated on a reimbursable basis.

These examples are intended to demonstrate that cross utilization of facilities has been successful in the Federal sector. However, we continue to seek new opportunities to reduce costs through sharing.

MCP—Fiscal Year 1981

[Dollars in millions]

Location	Project description	Amount
Army:		
Tripler	Hospital addition/alteration	$84.5
Fort Rucker	Hospital addition/alteration	27.5
Germany (Amberg, Bad Hersfeld, Hanau)	Health/dental clinic replacements	13.1
Germany (Dexheim, Goeppingen, Mannheim)	Health clinic replacements	7.4
Germany, Neurnberg	Dental clinic alteration	1.4
Panama, Fort Clayton	Dental clinic replacement	2.7
Korea, Yongsan	Dental clinic replacement	1.8
St. Louis, SPT CTR	Health clinic replacement	3.0
Fort Sam Houston and Fort Ord	Troop medical clinic replacements	8.4
Fort Leavenworth	Dental clinic-modernization	1.3
Fort Hunter-Liggett	Health clinic with beds	1.5
Fort Belvoir	Convert barracks to outpatient clinic	.5
Total Army		153.1
Navy:		
San Diego	Site preparation	25.0
Bethesda, phase IV, part I	Medical center modernization	23.0
Total Navy		48.0
Air Force:		
Castle	CMF/dental clinic ADAL	17.0
Wurtsmith	CMF/dental clinic ADAL	11.8
Hanscom	Clinic/dental clinic replacement	7.0
Elmendorf	Utility and life safety upgrade	4.0
Pope	Dental clinic replacement	1.8
Scott	Dental clinic replacement	4.2
Wilford Hall	Linear accelerator	.9
Total Air Force		46.7
Total DOD		247.8

OSD HOSPITAL PLANNING REVIEW—JUNE 1980 LONG RANGE PLAN FOR PROPOSED MEDICAL MCP

Location	Service	Description	Cost
FISCAL YEAR 1982			
Regions 1 and 2:			
San Diego Calif	Navy	NRMC replacement, part 2	$202,000
Travis AFB, Calif	Air Force	Hosp. Util/life safety upgrade	2,700
Region 3:			
Fort Carson, Colo	Army	Hospital replacement	87,400
Region 4:			
Davis-Monthan	Air Force	Food insp. Fac. Rpmt	430
Region 5:			
Sheppard AFB, Tex	Air Force	Hosp. Util./life safety upgrade	4,350
Region 6:			
Wright Patterson AFB, Ohio	Air Force	CMF/DC Add-Alt	108,400
Region 7:			
Keesler AFB, Miss	Air Force	Food insp. fac. rpmt	430
Regions 8 and 9:			
Annapolis, Md	Navy	Branch medical clinic/add upgrade	3,000

OSD HOSPITAL PLANNING REVIEW—JUNE 1980 LONG RANGE PLAN FOR PROPOSED MEDICAL MCP—Continued

Location	Service	Description	Cost
Subtotal			408,710
Europe:			
Frankfurt, Germany	Army	Hospital alteration	25,000
Subtotal			25,000
Pacific:			
Hickam AFB, Hawaii	Air Force	Med food insp. fac. rpmt	842
Subtotal			842
Total			434,552
FISCAL YEAR 1983			
Regions 1 and 2:			
Mare Island, Calif	Navy	Med/dent, clinic rpmt	$8,300
Port Hueneme, Calif	Navy	Medical clinic	8,200
March AFB, Calif	Air Force	DC/area lab. rpmt	5,600
Region 3:			
Fort Leavenworth, Kans	Army	Hospital elec./mech. upgrade	9,820
Minot AFB, N. Dak	Air Force	CMF/DC Rmpt	34,000
Hill AFB, Utah	Air Force	Occ. hlth. clin. rpmt	2,900
Region 4:			
Fort Bliss, Tex	Army	Med dept. (Vet. Svc.)	455
Region 5:			
Carswell AFB, Tex	Air Force	CMF add-alter/DC rpmt	34,000
Lackland AFB, Tex	Air Force	Clin. invest. fac. rpmt	6,000
Regions 6 and 7:			
Redstone Arsenal, Ala	Army	Preventive med. facility	516
Region 8:			
Fort Jackson, S.C	Army	Hospital elec/mech upgrade	14,915
Region 9:			
Letterkenny, Pa	Army	Health clinic rpmt	851
Bethesda, Md	Navy	Medical center modernization phase IV	28,000
Subtotal			153,557
OVERSEAS			
Europe:			
Bremerhaven	Army	Hospital renov./altr	21,795
REF Alconbury, England	Air Force	Clinic/DC rpmt	14,000
Aviano, Italy	Air Force	Clinic altr	300
Subtotal			36,095
Pacific:			
Tripler AMC, Hawaii	Army	Hospital add./altr	68,000
Schofield Bks, Hawaii	Army	Dental clinic rpmt	2,770
Osau, AB, Korea	Air Force	CMF/DG rpmt	19,000
Subtotal			89,770
Panama:			
Coco Solo, Panama	Army	Health/dental clinic	3,044
Gorgas Hosp, Panama	Army	Hosptial alter	5,500
Subtotal			8,544
Total			287,966
FISCAL YEAR 1984			
Region 1:			
Fort Lewis, Wash	Army	MAMC rpmt. hospital	$143,545
Bremerton, Wash	Navy	Branch med.dental clinic, NAVSHPYD, Puget Sound.	7,000

OSD HOSPITAL PLANNING REVIEW—JUNE 1980 LONG RANGE PLAN FOR PROPOSED MEDICAL MCP—Continued

Location	Service	Description	Cost
Region 2:			
Travis AFB, Calif	Air Force	CMF/DC/ASF	124,500
San Diego, Calif	Navy	Branch medical clinic (NAS North Island)	7,000
Twenty-nine Palms, Calif	Navy	Dental clinic	2,400
San Diego, Calif	Navy	NAVREGMEDCEN replacement, part 3, (equip. procurement).	25,000
San Nicholas Island, Calif	Navy	Medical clinic	674
Regions 3, 4, and 5:			
Fort Sill, Okla	Army	Hospital elec./mech. upgrade	6,050
Regions 6 and 7:			
Anniston, AD, Ala	Army	Health clinic	880
Pensacola, Fla	Navy	Branch med./dent. clinic, NAS Pensacola	7,000
Region 8:			
Camp LeJeune, N.C	Navy	Branch medical/dental clinic French Creek/ Hadnot Point.	10,000
Norfolk, Va	Navy	Environmental health center	2,800
Fort Lee, Va	Army	Hospital health center	9,270
Fort Lee, Va	Army	Med dept. fac. (Vet. Svc.)	931
Region 9:			
New London, Conn	Navy	Hospital addition	11,000
Newport, R.I	Navy	Hospital replacement	17,000
Subtotal			375,050
OVERSEAS			
Europe:			
Augsberg, Germany	Army	Hospital Renovation	16,232
Germersheim, Germany	Army	Med. dept. fac. (vet. svc.)	530
Subtotal			16,762
Alaska/Pacific:			
Pearl Harbor, Hawaii	Navy	Branch med./dental clinic MCAS Kaneohe Bay	11,000
Camp Humphrey, Korea	Army	Health clinic Addn	835
Camp Casey, Korea	Army	Health clinic w/beds	3,723
Subtotal			15,558
Total			407,370

Question 2. Apparently, DoD hospital commanders refer their patients for care to CHAMPUS providers or put them on aeromedical evacuation flights to other military hospitals for treatment. These alternative means of providing care of DoD beneficiaries are used, according to GAO, because the individual DoD hospital commanders do not have to pay for such services out of his own budget. Such alternative means of treatment can be costly. What has DoD done, or does it plan to do, to correct this situation?

Answer. While there may be isolated instances where commanders refer patients to CHAMPUS because of local budgetary constraints, we have no evidence that indicates such practices are widespread. DoD Hospital commanders utilize alternative means of delivering health care to DoD beneficiaries when such care is not immediately available at a DoD direct care facility. Commanders may refer active duty personnel either to other local Federal medical facilities, to local civilian providers, or to distant DoD medical facilities via the DoD aeromedical evacuation system. Non-active duty DoD beneficiaries may be referred to local civilian providers under CHAMPUS, to other local Federal medical facilities, or to distant DoD medical facilities via the aeromedical evacuation system. Hospital commanders base their referral decisions primarily on an evaluation of each patient's medical needs, and the individual DoD medical facility's capability to render adequate care. There are some statutory requirements affecting patient referral from direct care facilities to CHAMPUS. By law, if a non-active duty beneficiary resides within 40-miles of a Uniformed Services hospital, and they require inpatient care, they must use that Uniformed Services hospital if space and professional capability to meet the patient's needs is available. If not, a Certificate of Nonavailability (CNA) is issued and the individual directed to seek care from civilian sources. The issuance of CNA's is carefully monitored by the military Surgeons General. Further, CHAMPUS cannot provide benefits for civilian inpatient services rendered a "40-mile resident" if a CNA is not attached to the claim.

The Department of Defense has been looking for better ways to maximize use of its direct care resources. In 1977 Health Affairs approved a new concept, "COOPERATIVE CARE," which permits a military medical facility to retain primary control of a patient even though it cannot provide a needed support service or supply (such as physical therapy, psychiatric services or specialized durable medical equipment). Previously if the medical facility did not have sufficient funds to purchase the required support services/supplies, it was necessary for the patient to be completely disengaged from the direct care system before CHAMPUS could extend benefits. Because of COOPERATIVE CARE, this is no longer the case.

Also, the Air Force and CHAMPUS have recently conducted a test where by CHAMPUS-paid civilian physicians provide their services in Air force hospitals. The purpose of the test was to determine the feasibility of a joint arrangement which would provide interim CHAMPUS support to the Air Force direct care system during periods when a facility would otherwise be required to close or limit a service due to lack of appropriate physician specialists. This has proved to be a very acceptable approach and it is being expanded.

Finally, to the extent that local budgetary contraints may influence patient transfer decisions, the Capitation Budgeting Test, which is currently being evaluated, gives local commanders the resources to provide total care (including CHAMPUS) to the population being supported. This concept removes the option to shift the cost to some other entity; however, the outcome of the test is yet to be determined.

Question 3. Can you please provide for insertion in the record for fiscal year 1979 on a DoD health facility-by-facility basis, the dollar amount of (a) supplemental care, (b) contractual care, and (c) if possible, the amount of CHAMPUS care provided for inpatient and outpatient services because of its unavailability in a uniform service facility?

Answer. The information requested must be developed at facility level. We have taken action to get the information and anticipate that a complete response can be submitted to your office by September 30, 1980. This approach was discussed with Mr. Mertz of your office.

[Additional material subsequently received for the record follows:]

The attached facility listing reflects the cost of supplemental care, contractual care and CHAMPUS inpatient care within a 40-mile radius of military hospitals. The cost of CHAMPUS outpatient care is not included because the cost data are not related to the availability of care in the direct care system. Beneficiaries have a choice of getting their outpatient care in the direct care system or under CHAMPUS. A non-availability statement is not required.

CHAMPUS inpatient cost data must be used with discretion for the following reasons: (*a*) data reflect the cost of care provided within a 40-mile radius of a direct care facility rather than the cost of care provided to beneficiaries who live within a 40-mile radius of a direct care facility, (*b*) data are based on the first 3 digits of the zip code, which extends beyond the 40-mile radius in most cases, and (3) costs are duplicated in overlapping 40-mile catchment areas, such as the Washington area, San Antonio area, etc. Thus, the total of the CHAMPUS inpatient column of the attachment would be an overstatement of the actual cost. Steps are being taken to improve the validity of the CHAMPUS cost data, i.e., expanding the number of zip code digits used and using the patients residence rather than the institutional address in the cost finding process. (NOTE.—The question does not specify any boundaries; however, since the subject is Federal sharing, cost data are provided for the United States only.)

ARMY MEDICAL FACILITIES

[Dollars in thousands]

Facility and location	Fiscal year 1979 cost		
	Supplemental care	Contractual care	CHAMPUS inpatient
William Beaumont Army Medical Center, El Paso, Tex	$250	$673	$1,258
Brooke Army Medical Center, Fort Sam Houston, Tex	378	181	2,182
Fitzsimons Army Medical Center, Aurora, Calif	280	499	2,749
Dwight D. Eisenhower Army Medical Center, Fort Gordon, Ga	308	763	2,076
Letterman Army Medical Center, Presidio of San Francisco, Calif	422	354	7,718
Madigan Army Medical Center, Tacoma, Wash	373	98	3,597
Walter Reed Army Medical Center, Washington, D.C	128	487	6,599
Tripler Army Medical Center, Tripler AMC, Hawaii	280	236	1,821
U.S. Army Hospital, Fort Wainwright, Alaska	233	146	523
DeWitt Army Hospital, Fort Belvoir, Va	25	429	4,335
Martin Army Hospital, Fort Benning, Ga	401	486	4,492
Womack Army Hospital, Fort Bragg, N.C	303	466	4,926
U.S. Army Hospital, Fort Campbell, Ky	141	258	2,380
U.S. Army Hospital, Fort Carson, Colo	143	41	5,687
Cutler Army Hospital, Fort Devens, Mass	275	244	4,572
Walson Army Hospital, Fort Dix, N.J	57	303	7,512
McDonald Army Hospital, Fort Eustis, Va	23	201	17,446
Darnall Army Hospital, Fort Hood, Tex	106	392	5,140
Raymond W. Bliss Army Hospital, Fort Huachuca, Ariz	132	85	139
Moncrief Army Hospital, Fort Jackson, S.C	197	224	1,588
Ireland Army Hospital, Fort Knox, Ky	184	648	2,357
Munson Army Hospital, Fort Leavenworth, Kans	132	254	3,783
Kenner Army Hospital, Fort Lee, Va	156	173	2,996
General Leonard Wood Army Hospital, Fort Leonard Wood, Mo	74	249	165
Noble Army Hospital, Fort McClellan, Ala	152	147	1,060
Kimbrough Army Hospital, Fort George G. Meade, Md	62	547	9,312
Patterson Army Hospital, Fort Monmouth, N.J	38	179	2,864
Silas B. Hayes Army Hospital, Fort Ord, Calif	81	57	3,186
U.S. Army Hospital, Fort Polk, La	188	273	2,100
U.S. Army Hospital, Redstone Arsenal, Ala	186	217	2,565
Irwin Army Hospital, Fort Riley, Kans	187	333	3,278
Reynolds Army Hospital, Fort Sill, Okla	221	347	2,647
Tuttle Army Hospital, Fort Stewart, Ga	67	159	3,297
U.S. Army Hospital, West Point, N.Y	54	79	654
Lister Army Hospital, Fort Rucker, Ala	201	120	2,310

NAVY MEDICAL FACILITIES

[Dollars in thousands]

Facility and location	Fiscal year 1979 cost		
	Supplemental care	Contractual care	CHAMPUS inpatient
National Naval Medical Center, Bethesda, Md	$19.5		$6,599
Naval Regional Medical Clinic, Annapolis, Md		72.0	9,330
Naval Regional Medical Clinic, Quantico, Va	.8	84.3	2,922
Naval Regional Medical Center, Bremerton, Wash	54.1	2.8	7,573
Naval Regional Medical Center, Camp Lejeune, N.C	138.0		1,524
Naval Hospital, Cherry Point, N.C	53.8	116.3	1,524
Naval Regional Medical Center, Camp Pendleton, Calif	15.0		22,482
Naval Regional Medical Center, Charleston, S.C	129.6		1,798
Naval Hospital, Beaufort, S.C	62.5	128.3	4,304
Naval Regional Medical Center, Corpus Christi, Tex	67.7	130.6	2,306
Naval Regional Medical Center, Great Lakes, Ill	240.0	97.0	2,280
Naval Regional Medical Center, Jacksonville, Fla	181.3		7,483
Naval Regional Medical Clinic, Key West, Fla	33.6	53.3	1,974
Naval Regional Medical Center, Long Beach, Calif	341.2		22,288
Naval Regional Medical Clinic, Port Hueneme, Calif	68.8	18.4	7,219

NAVY MEDICAL FACILITIES—Continued

[Dollars in thousands]

Facility and location	Fiscal year 1979 cost		
	Supplemental care	Contractual care	CHAMPUS inpatient
Naval Regional Medical Center, Memphis, Tenn	80.9	32.3	3,760
Naval Submarine Medical Center, New London, Conn	157.0	132.0	2,155
Naval Regional Medical Center, Newport, R.I.	86.0	114.5	2,106
Naval Regional Medical Clinic, Portsmouth, N.H	23.0	41.0	17,266
Naval Regional Medical Center, Oakland, Calif	218.4	1.8	7,718
Naval Hospital, Lemoore, Calif	3.7	—	1,513
Naval Regional Medical Center, Orlando, Fla	217.3	67.1	8,337
Naval Aerospace and Regional Medical Center, Pensacola, Fla	317.0	135.4	6,282
Naval Regional Medical Center, Philadelphia, Pa	134.0	35.1	8,126
Naval Regional Medical Center, Portsmouth, Va	478.5	216.9	17,266
Naval Regional Medical Center, San Diego, Calif	188.8	293.6	15,818
Naval Regional Medical Clinic, New Orleans, La	45.0	—	n.a.

AIR FORCE MEDICAL FACILITIES

[Dollars in thousands]

Facility and location	Fiscal year 1979 cost		
	Supplemental care	Contractual care	CHAMPUS inpatient
USAF Academy Hospital, USAF Academy, Colo	$89	$73	$7,416
USAF Hospital Altus, Altus AFB, Ok	5	117	2,273
Malcolm Grow Medical Center, Andrews AFB, D.C.	48	—	6,314
USAF Hospital Barksdale, Barksdale AFB, La	283	43	2,028
USAF Hospital Beale, Beale AFB, Calif	16	—	4,601
USAF Hospital Bergstrom, Bergstrom AFB, Tex	21	122	5,796
USAF Hospital Blytheville, Blytheville AFB, Ariz	38	49	489
USAF Hospital Cannon, Cannon AFB, N. Mex	48	25	37
USAF Regional Hospital Carswell, Carswell AFB, Tex	201	142	5,708
USAF Hospital Castle, Castle AFB, Calif	38	71	1,371
USAF Hospital Chanute, Chanute AFB, Ill	133	86	562
USAF Hospital Columbus, Columbus AFB, Miss	23	66	2,080
USAF Hospital Davis Monthan, Davis Monthan AFB, Ariz	242	75	4,100
USAF Hospital Dover, Dover AFB, Del	10	33	323
USAF Hospital Dyess, Dyess AFB, Tex	92	224	1,535
USAF Hospital Edwards, Edwards AFB, Calif	55	173	701
USAF Regional Hospital Eglin, Eglin AFB, Fla	117	29	4,560
USAF Hospital Ellsworth, Ellsworth AFB, S. Dak	103	129	674
USAF Hospital Elmendorf, Elmendorf AFB, Alaska	206	203	613
USAF Hospital England, England AFB, La	39	50	1,558
USAF Hospital Fairchild, Fairchild AFB, Wash	162	47	1,087
USAF Hospital F. E. Warren, F. E. Warren AFB, Wyo	40	123	171
USAF Hospital George, George AFB, Calif	11	41	6,773
USAF Hospital Grand Forks, Grand Forks, AFB, N. Dak	183	257	685
USAF Hospital Griffiss, Griffiss AFB, N.Y	131	95	1,684
USAF Hospital Hill, Hill AFB, Utah	224	191	2,065
USAF Hospital Holloman, Holloman AFB, N. Mex	1	87	337
USAF Hospital Homestead, Homestead AFB, Fla	103	97	6,640
USAF Hospital Kirtland, Kirtland AFB, N. Mex	218	196	2,293
USAF Medical Center Keesler, Keesler AFB, Miss	176	—	2,596
USAF Hospital K. I. Sawyer, K. I. Sawyer AFB, Mich	126	—	469
Wilford Hall USAF Medical Center, Lackland AFB, Tex	158	29	2,182
USAF Hospital Langley, Langley AFB, Va	35	20	3,924
USAF Hospital Laughlin, Laughlin AFB, Tex	6	64	52
USAF Hospital Little Rock, Little Rock AFB, Ariz	123	86	3,779
USAF Hospital Loring, Loring AFP, Maine	133	42	438
USAF Hospital Luke, Luke AFB, Ariz	149	22	6,514
USAF Regional Hospital MacDill, MacDill AFB, Fla	150	36	9,012

AIR FORCE MEDICAL FACILITIES—Continued

[Dollars in thousands]

Facility and location	Fiscal year 1979 cost		
	Supplemental care	Contractual care	CHAMPUS inpatient
USAF Hospital Malmstrom, Malmstrom AFB, Mont	102	112	1,189
USAF Regional Hospital March, March AFB, Calif	67	412	15,134
USAF Hospital Mather, Mather AFB, Calif	39		5,217
USAF Regional Hospital Maxwell, Maxwell AFB, Ala	243	115	2,387
USAF Hospital McConnell, McConnell AFB, Kans	195	55	2,622
USAF Regional Hospital Minot, Minot AFB, N. Dak	171	146	657
USAF Hospital Moody, Moody AFB, GA	77	412	1,745
USAF Hospital Mountain Home, Mountain Home AFB, Idaho	96	51	834
USAF Hospital Myrtle Beach, Myrtle Beach AFB, S.C	34	12	944
USAF Hospital Nellis, Nellis AFB, Nev	248		3,723
Ehrling Bergquist USAF Regional Hospital, Offutt AFB, Nebr	574	386	802
USAF Hospital Patrick, Patrick AFB, Fla	117	30	4,259
USAF Hospital Pease, Pease AFB, N.H	91	57	700
USAF Hospital Plattsburgh, Plattsburgh AFB, N.Y	112	99	1,211
USAF Hospital Reese, Reese AFB, Tex	28	26	1,050
USAF Hospital Robins, Robins AFB, Ga	104	63	1,994
Scott USAF Medical Center, Scott AFB, Ill	97	218	3,277
USAF Hospital Seymour Johnson, Seymour Johnson AFB, N.C	101	81	3,913
USAF Regional Hospital Shaw, Shaw AFB, S.C	10	137	2,532
USAF Regional Hospital Sheppard, Sheppard AFB, Tex	13	120	2,275
USAF Hospital Tinker, Tinker AFB, Ok	219	38	5,461
David Grant USAF Medical Center, Travis AFB, Calif	98	217	7,772
USAF Hospital Tyndall, Tyndall AFB, Fla	104		1,723
USAF Hospital Vandenberg, Vandenberg AFB, Calif	53		1,080
USAF Hospital Whiteman, Whiteman AFB, Mo	32	36	949
USAF Hospital Williams, Williams AFB, Ariz	99	37	6,514
USAF Medical Center, Wright Patterson AFB, Ohio	126	2	1,402
USAF Hospital Wurtsmith, Wurtsmith AFB, Mich	83	82	380

Senator Percy. I would like to add just as a footnote, though, for the record, when we get down to it, there are only 8 Public Health Service hospitals, where DOD and VA have together 300 hospitals. So we are not dealing with very much when we are talking about incorporating them, but it is another added factor that we will certainly take into account. We will try to work that out.

Our final witness today is Dr. Donald L. Custis, Chief Medical Director, Department of Medicine and Surgery, Veterans' Administration.

Dr. Custis, would you be good enough to introduce your colleagues that are with you? Your full testimony will be incorporated in the record. You can summarize it in any way you see fit.

TESTIMONY OF DONALD L. CUSTIS, M.D., CHIEF MEDICAL DIRECTOR, DEPARTMENT OF MEDICINE AND SURGERY, VETERANS' ADMINISTRATION; ACCOMPANIED BY WILLIAM JACOBY, M.D., DEPUTY CHIEF MEDICAL DIRECTOR; AND ROBERT COY, DEPUTY GENERAL COUNSEL

Dr. Custis. Thank you, Mr. Chairman.

Mr. Chairman, I am pleased to introduce my Deputy, Dr. Bill Jacoby, and the Deputy General Counsel, Veterans' Administration, Mr. Robert Coy. I will present an abbreviated version of the longer statement that has been previously submitted for the record.

I am pleased to appear before you today to present our views on S. 2958, a draft bill entitled "The Federal Interagency Medical Resources Sharing and Coordination Act of 1980."

The Congress had the foresight to recognize the utility of the sharing concept for the VA medical care system in the early 1960's. Public Law 89-785, enacted in November 1966, gave the Veterans' Administration its first statutory authority to enter into agreements to receive from and share with medical schools, hospitals, research centers throughout the country the most advanced technology, information, and certain specialized medical resources.

Veterans' Administration sharing activity has since grown dramatically. The number of sharing contracts has increased 15 times since the enactment of this sharing authority 14 years ago.

Sharing has been beneficial not only to the VA but to the community as well. New items and new services have been added each year since the sharing law was enacted. The sharing agreements have resulted in better cooperation between VA hospitals and their community counterparts and in better utilization of medical specialists, technologies, and facilities.

The Veterans' Administration agreements involve other Federal agencies such as the Departments of Health and Human Services, Defense, Energy, the Office of Personnel Management, NASA, and the Federal Aviation Administration. We believe our extensive activities in this area evidence our commitment to medical care cost containment efforts in the Federal sector.

In response to congressional requests, we are now furnishing progress reports on the Veterans' Administration's administrative efforts to expand sharing. Clearly, however, there are certain legal obstacles that prevent maximizing interagency sharing.

As a natural outgrowth of the differing statutes and missions, administrative interpretations of what constitutes acceptable sharing vary widely among agencies. In general, there are insufficient incentives and often very clear disincentives militating against more interagency sharing.

Much of this has been attributed to differing headquarters-level reimbursement mechanisms and in some cases to insufficient agency guidance in identifying sharing opportunities and implementing agreements. Although the Veterans' Administration has been active in initiating cost-saving agreements under the Economy Act, reimbursement problems surrounding the sharing of medical services have been a major obstacle.

Our own sharing authority in section 5053 of title 38 is limited in scope to specialized medical resources. Specialized medical resources are those which, because of cost, limited availability or unusual nature, are either unique in the medical community or are subject to maximum utilization only through mutual use.

The Veterans' Administration strongly supports the goal of achieving increased interagency cooperation in the use of Federal medical resources. We also applaud the development of incentives to increase sharing, particularly the bill's provision that would credit reimbursement to the specific facility which provided the medical service.

Central to achieving a health care system sensitive to and able to meet the needs of veteran beneficiaries is independence to manage that system and to plan its growth. The draft bill reflects recognition of the importance of balancing the goal of greater interagency sharing with the commitments this agency and the DOD have to their primary beneficiaries.

In this connection, it must be clear that the type of care to be shared and the class of beneficiary to be treated is left to the discretion of the treating agency so as not to be in conflict with the primary mission of that agency.

We are also committed and working toward development of a clearly defined role to enable the VA health care system to serve as a resource to meet DOD contingency planning needs.

While the Veterans' Administration has a potentially important role to play in providing needed medical care or resources for active duty military members, neither our facilities nor our mission was designed to furnish health care services to Armed Forces' dependents.

The affinity and close association that would readily facilitate increased sharing between the VA and the military services is relatively unique and we would welcome the opportunity to build on and expand that role through incentives rather than through mandates.

While we have focused primarily on the very broad issues raised by the bill, we have several concerns which should not escape attention. One is the provision that would appear to make sharing arrangements operative upon agreement by facility directors subject only to subsequent revocation after submission to agency headquarters. We believe this provision does not allow sufficient review at the department level, which we consider essential in the light of the magnitude of the expenditures involved and the possible impact of such agreements beyond the local facility itself.

Second, rather than directing providing agencies to prepare extensive reports to a series of committees, we would commend to your attention the model of the VA's sharing law which, in title 38, section 5057, simply calls for a report to Congress on VA's sharing activities.

There are other issues in S. 2958, for example, reimbursement procedures, personnel ceiling exemptions, which we propose to address in a more detailed report on the bill, and which we would like to discuss further with the committee in an effort to improve S. 2958.

[Subsequently, the Veterans' Administration furnished the following information:]

We take this opportunity to further address two issues raised by the bill's provisions: reimbursements from sharing arrangements and exemptions from personnel ceilings for personnel acquired to provide shared services. Regarding reimbursements from sharing arrangements, failure to credit the reimbursement to the facility that provided the medical services has been frequently cited as an obstacle to increased sharing of medical resources among federal agencies. Our failure to credit the reimbursements to the facility providing the service has resulted from the requirements that reimbursements cannot be obligated until earned and cannot be obligated beyond the period of availability of the appropriation which funded the services. We would perfer that the bill be amended to make clear that all reimbursements from all sources, including sharing arrangements, be available for obligation not only during the fiscal year during which the services were provided, but during the following fiscal year as well.

Dr. Custis. In summary, we favor the principle of interagency sharing of medical resources. Such authority would enhance Federal providers abilities to meet their missions in a more cost-effective manner and with suitable changes in clarification to insure the permissive nature of access, we would be pleased to support the bill.

Mr. Chairman, this completes my prepared statement. I would be pleased, as would my colleagues, to answer any questions you might have.

Senator Percy. Thank you very much, indeed, Dr. Custis. I would appreciate your telling Max Cleland, since I talked with him, how much we appreciate your cooperation. You yourself, without any question, have a very progressive record in the sharing area, well respected in other agencies as a force in the VA on the side of interagency cooperation, cost efficiency, and promoting sharing, which would improve health care.

We very much appreciate Veterans' Administration's support of the legislation. We will enjoy working with you in finding ways to further perfect it. We will look forward to working with you in pursuing these mutual goals and to remove whatever obstacles we can find, and promote progress toward increased coordination between Federal health providers.

I would like to ask you first, you describe the VA as being in the forefront among Federal agencies in initiating cross-servicing agreements under the Economy Act. How many of these agreements does the VA have with Defense and what was the dollar amount of shared services in 1979 for medical related services?

If you would like to provide that for the record, you certainly can if you don't have the information handy.

Dr. Custis. We will provide it for the record, Mr. Chairman.

[Subsequently, the Veterans' Administration furnished the following information:]

In 1979, the Veterans' Administration participated with the Department of Defense in the following array of cross-servicing agreements:

	Number	Amount
Medical services	9	$440,430
Laboratory services	1	4,989
Research	6	471,996
Total	16	917,415

In addition to the above, the following includes VA-DOD cross-servicing agreements for other than medical related support services:

	Number	Amount
Supply	3	$4,197
Laundry	2	79,665
Training	2	43,940
Maintenance/utilities	4	41,475
Total	11	169,277
Total medical related and other		1,086,692

Senator **Percy**. Do you feel the Federal Health Resource Sharing Committee has been effective in promoting sharing between the major Federal health care providers and, if not, what has hindered their progress, in your opinion?

Dr. **Custis**. I think the committee has accomplished a great deal, but in their accomplishments I would not include any great implementation of sharing arrangements. The sharing arrangements that I am aware of that have grown from the committee are those already mentioned.

The committee, however, has laid the groundwork that will enable, with this legislation, the agencies to get a head start and make more progress than they might otherwise had it not been for the good work of the committee. The committee, I think, also is to be credited with having set standards for productivity against which the potential for sharing can be appraised.

The committee, as also mentioned, has been effective in causing different agencies to reconsider the opening of new facilities and defer such opening.

Senator **Percy**. In your testimony, you state—and I will just quote from your testimony—"Neither our facilities nor our mission was designed to furnish health care services to Armed Forces dependents."

In GAO's 1978 report, numerous local VA hospital officials stated they actually were treating active duty and retired military members and their dependents in VA hospitals without adversely affecting the care of VA's primary beneficiaries. In view of this and the fact that many expensive diagnostic services can be provided to many types of patients on an outpatient basis, why does VA take the position that its 171 hospitals are not designed to furnish services for dependents of the Armed Forces?

Dr. **Custis**. Senator, we are very sensitive on the matter of entitlement. Our only authority to care for those not entitled under law is on a civilian humanitarian basis, plus what authority we have in our own sharing agreement for certain specified types of treatment covering only special medical program capabilities.

I think there is something else that I would like to insert at this time in talking about the matter of entitlement and our ability to care for those other than our primary beneficiaries. And that is, I think the military medical services must also appreciate, whereas they have suffered depletions in their personnel staffing, that the VA has to a lesser degree also had the same difficulty.

We, at the present time, are rationing health care to our own primary beneficiaries, and I think everyone should appreciate that we are not in a position, in any wholesale fashion, to assume responsibility for patients not included in our own legislated eligibility criteria. Our General Counsel may want to address that.

Senator **Percy**. In your statement, you said that the language in S. 2958, allowing sharing proposals to be operative upon local agreements with subsequent headquarter review is neither prudent nor needed.

Would you agree, however, that regulatory difficulties, like the one referred to by Mr. Yates earlier, in processing proposed sharing contracts are so time consuming and restrictive as to discourage their pursuit by local administrators.

Also, since S. 2958 would eliminate some of the restrictions on what type of services can be shared, isn't there a need to cut some of the redtape that is a disincentive to sharing at the local level?

Dr. CUSTIS. Yes, Mr. Chairman, I think there certainly is. I would submit with the changes in legislation that this bill provides, the delay in interpreting the law would be greatly obviated.

Senator PERCY. Your statement explains that there is a need for clarification to insure the permissive nature of access. Could you explain what you mean by this?

Dr. CUSTIS. I am sorry, would you repeat that?

Senator PERCY. I am quoting directly from your own statement. You explain there is a need for clarification to insure the permissive nature of access.

Could you expand on what you meant by that statement, the permissive nature of access?

Dr. CUSTIS. May I say this, Mr. Chairman, I arrived back in town last night after an absence of 10 days. I am very grateful to my staff and General Counsel for having prepared my statement. When you throw the words back at me, may I say they are other people's words?

Senator PERCY. You will stand on them but let's turn to them for explanation.

Dr. CUSTIS. I really don't know what that clause means.

Senator PERCY. It caused a little indecision in our mind as to what was meant by it.

Mr. COY. I might say, part of the problem is that your staff is very diligent and has been working and modifying this bill as we go along. What started out as our statement on one bill was modified to become a statement on another bill.

I think some of the earlier concerns were overcome. We just wanted to emphasize the importance of the permissive nature of the bill so that the provider would have some role in the determination of who would have access. There was one question with respect to page 5 of the bill.

Because of statutory priorities we have in our own legislative authority, we must assure our ability to provide care for service-connected veterans. The bill certainly is vastly improved. I don't think there is going to be a major problem.

Senator PERCY. Thank you very kindly.

We do intend to keep the record open for 2 weeks so that you can provide a more detailed report on some of the items that you referred to in the statement and we certainly would be glad to work with you in that time.

Finally, from a parochial standpoint, I might ask you to comment on whether or not the enactment of S. 2958 would enable and encourage the implementation of sharing arrangements such as the opportunity at North Chicago? As you recall, Navy officials had indicated their inpatient load at Great Lakes is so small that they have a potential additional 466 beds.

We have to keep in mind that the number of inpatients at Great Lakes has been declining for several years now. Could you comment on that situation: How much VA has spent at their North Chicago facility to upgrade its capacity to provide acute and intermediate medical care in the last 6 years or so; how much will the

VA need to spend in the next 6 years to renovate these facilities; and, why hasn't the Navy and VA attempted to share and avoid duplication?

A brief comment right now would be helpful and you can expand on that comment for the record.

Dr. Custis. Commenting briefly then, Mr. Chairman, the Navy entered into an affiliation agreement with the Chicago Medical School about 6 years ago. I am sorry, the VA. Sometimes I revert to my previous incarnation. The VA entered into an affiliation agreement with that school about 6 years ago. At that time, it was made very clear and documented in the record that the VA had no intention of upgrading the North Chicago Hospital to a tertiary care hospital, that it would remain a secondary-type-care institution.

There has been relatively little additional resource put into that hospital in those intervening years, nor do we intend to make any big investment in the way of major construction in the foreseeable future. There is a need to upgrade some of those buildings, including the installation of air conditioning.

We will provide for the record the exact amount of the money that has, in the way of new resources, been placed in North Chicago. I think as we approach, as we negotiate with the Navy as to what can be done in the way of increased sharing, we can immediately show that this will be an example of what Dr. Moxley was talking about; namely, that what might seem a very simple thing to do can become rather complex.

I assure you, and we assure the Navy, that we will do everything we possibly can, but we were reluctant to have this as an example used in this hearing, because of the inability due to potential complexities to talk about real numbers, staffing and other resources that might be exchanged in such an agreement.

For example, if we were to abandon the main buildings on the VA side of that highway and make full use of the Navy's offer to come join them in a very modern building, and suddenly the country should get into some major contingency and the Navy suddenly find that they have to reoccupy, fully, the Great Lakes Naval Hospital, we would be hard pressed, having literally moved out and abandoned the buildings in question at North Chicago. It might prove to be a very shortsighted arrangement.

So it is complex but we will pursue it and we will do all we can to accommodate the Navy's needs up there.

[The prepared statement of Dr. Custis, responses to written question and additional material follows:]

TESTIMONY OF

DONALD L. CUSTIS, M.D.

CHIEF MEDICAL DIRECTOR

DEPARTMENT OF MEDICINE AND SURGERY

VETERANS ADMINISTRATION

BEFORE THE

COMMITTEE ON GOVERNMENTAL AFFAIRS

UNITED STATES SENATE

July 30, 1980

Mr. Chairman and Members of the Committee:

I am pleased to appear before you today to present our views on S.2958, a draft bill entitled the "Federal Interagency Medical Resources Sharing and Coordination Act of 1980."

This bill, which was introduced on July 23, 1980, as S. 2958, is intended to clarify and expand the authority of the Veterans Administration and the Department of Defense in order to facilitate interagency sharing of medical care and medical care support resources. I would note that this bill is a revised version of S.2613 and reflects a number of changes which improve that measure. The bill would establish a Federal Interagency Health Resources Committee composed of the Secretary of Defense and the Administrator of Veterans Affairs. That committee would be charged with establishing VA-DOD policy on interagency sharing of medical resources. The bill would mandate that the committee assess opportunities for sharing federal health resources to include the potential for sharing in plans for additional Veterans Administration or Department of Defense medical facilities and acquisition of major new medical equipment; identify sharing opportunities that will not adversely affect quality or priority of care provided; and prescribe policies and procedures to maximize Veterans Administration and Department of Defense sharing. The committee would also be charged with coordinating the establishment, and monitoring implementation, of uniform interagency health care policies and procedures including coordinated planning for future development of each agency's direct health care delivery system.

The bill would mandate that the committee prescribe guidelines directing commanding officers and directors of each VA and DOD health care facility to enter into interagency cooperative sharing arrangements with other health care facilities of such providing agencies whenever possible. Under such arrangements, primary beneficiaries eligible for direct health care in a federal facility could receive medical care at a providing facility of another agency. The scope of services subject to sharing could include any medical care or medical care support resource.

The bill would also provide that availability of hospital or medical care to beneficiaries of an agency other than the providing agency would be on a referral basis. Facility directors who would negotiate such arrangements would determine that the agreement would not adversely affect the quality of care and priority access for medical services of the providing agency's primary beneficiaries. Reimbursement, to be based on costs negotiated by the heads of the participating facilities, would be credited to the specific provider facility. Funds reimbursed could be obligated for the fiscal year following the fiscal year in which the resource was provided. Sharing arrangements would become operative upon agreement between facility managers pending disapproval by agency headquarters.

The bill includes caveats to the effect that the proposed joint responsibilities of the concerned agency heads as to uniform direct health care should not be construed to alter the individual agencies' statutory responsibilities with regard to the provision of medical services, and that the act would not preclude sharing of medical resources under any other law among all federal providers.

The bill would also authorize agencies to request both relief from applicable personnel ceilings or other restrictions, and the funds to acquire the resources necessary to treat beneficiaries of other providing agencies.

Finally, the bill contains a requirement for extensive annual reporting to eight congressional committees from each providing agency with regard to specific aspects of implementation.

Congress had the foresight to recognize the utility of the sharing concept for the VA medical care system in the early 1960s. Public Law 89-785, enacted in November 1966, gave the Veterans Administration its first statutory authority to enter into agreements to receive from and share with medical schools, hospitals, and research centers throughout the country the most advanced medical technology, information, and certain specialized medical resources. This authority was intended to improve the quality of hospital care and other medical services provided veterans by authorizing the Administrator to receive and share specialized medical resources without diminution of services to veterans.

Veterans Administration sharing activity has grown dramatically. The number of sharing contracts has increased 15 times since enactment of sharing authority 14 years ago. In 1967, only 15 Veterans Administration hospitals had agreements to share specialized medical resources under section 5053 of title 38, U.S.C.; those 15 agreements had a total monetary value of services bought and sold of $118,875. In 1979, there were 99 Veterans Administration medical centers having 240 sharing contracts for a total value of services exchanged amounting to $20,198,677. Sharing has been beneficial not only to the VA, but to the community as well. Additionally, new items and new services have been added each year since the sharing law was enacted. The sharing agreements have resulted in better cooperation between VA hospitals and their community counterparts, and in better utilization of medical specialists, technologies, and facilities.

Together with our sharing efforts with community facilities, VA has enthusiastically sought increased cooperation among federal medical systems. I would like to emphasize that the Veterans Administration has for many years been in the forefront among federal agencies in initiating "cross-servicing" agreements under the Economy Act. The Veterans Administration currently has 64 active field facility cross-servicing medical service and research agreements, 23 such agreements between VA Central Office and other federal agency headquarters and 18 active agreements to procure medical supplies with other federal agencies in the interest of economy. These Veterans Administration agreements involve other federal agencies such as the Departments of Health and Human Services, Defense, Justice, and Energy, and the Office of Personnel Management, NASA, and the Federal Aviation Administration. We believe our extensive activities in this area evidence our commitment to medical care cost containment efforts in the federal sector.

In response to congressional requests, we are now furnishing progress reports on the Veterans Administration's administrative efforts to expand sharing. Clearly, however, there are certain legal obstacles that prevent maximizing interagency sharing. For example, we have been advised that the military medical services lack specific legislative authority to provide medical care to beneficiaries of other agencies under sharing arrangements. Apparently, the major basis under which Department of Defense hospitals exchange services is under section 686 of title 31, U.S.C., the Economy Act.

As a natural outgrowth of the differing statutes and missions, administrative interpretations of what constitutes acceptable sharing vary widely among agencies. In general, there are insufficient incentives and often clear disincentives militating against more interagency sharing. Much of this has been attributed to differing headquarters-level reimbursement mechanisms, and in some cases to insufficient agency guidance in identifying sharing opportunities and implementing agreements. Although the Veterans Administration has been active in initiating cross-servicing agreements under the Economy Act, reimbursement problems surrounding the sharing of medical services have been a major obstacle.

Our own sharing authority in section 5053, title 38, U.S.C., is limited in scope to specialized medical resources. "Specialized" medical resources are those which because of cost, limited availability, or unusual nature, are either unique in the medical community or are subject to maximum utilization only through mutual use.

Despite several limitations, improvements have occurred in the last few years in the sharing of specialized medical resources. These improvements include more awareness at central office level and at field activities of interagency resources, reduced processing time for gaining sharing agreement approval and increased guidance to field activities on the mechanics of sharing medical resources.

In addition, the Veterans Administration has played an important role in developing greater coordination in health services planning by federal agencies through its role on the Federal Health Resources Sharing Committee. Initial interagency meetings in August and September 1977 to explore joint federal planning and sharing of specialized medical resources culminated in the chartering of the Federal Health Resources Sharing Committee in February 1978. The committee (FHRSC) whose members represent the Air Force, Army, Department of Defense, Navy, Public Health Service and the Veterans Administration has met 16 times. In order to respond effectively to findings and recommendations from the Congress, OMB and GAO, the committee has to date established six subcommittees. They have made substantive progress in developing guidelines and criteria for assessing and justifying the need for an appropriate location of particular specialized medical services; in developing program utilization standards, and in actively exploring sharing opportunities in specific geographic areas. Comprehensive subcommittee reports have been presented to the parent committee. The committee is also developing a standard format for use by each agency in obtaining a current listing of all federal sharing arrangements. A computerized, consolidated listing of all interagency sharing arrangements is in the final stage of preparation.

The Veterans Administration strongly supports the goal of achieving increased interagency cooperation in the use of federal medical resources. We also applaud the development of incentives to increase sharing, particularly the bill's provision that would credit reimbursement to the specific facility which provided the medical service. The proposed legislation represents one means of encouraging an important goal.

Congress has charged the VA with providing a broad array of medical services to care for and treat veterans suffering from service-incurred and other disabilities. The Veterans Administration health care system represents a commitment to the promise of quality care for veterans. In reviewing the proposed Federal Interagency Medical Resources Sharing and Coordination Act of 1980, we must consider whether this proposed attempt to achieve improved efficiency and economy would also serve the veteran, or conversely whether it would damage the system upon which the veteran has relied, and deprive the veteran of promised quality VA care.

Central to achieving a health care system sensitive to and able to meet the needs of veteran beneficiaries is independence to manage that system and plan its growth. The draft bill reflects recognition of the importance of balancing the goal of greater interagency sharing with the commitments this Agency and the DOD have to their primary beneficiaries. In this connection, it must be clear that the type of care to be shared, and the class of beneficiary to be treated, is left to the discretion of the treating agency so as not to be in conflict with the primary mission of that agency.

We are also committed and working toward development of a clearly-defined role to enable the VA health care system to serve as a resource to meet DOD contingency planning needs. While the Veterans Administration has a potentially important role to play in providing needed medical care or resources for active duty military members, neither our facilities nor our mission was designed to furnish health care services to

best copy available

Armed Forces' dependents. The affinity and close association that would readily facilitate increased sharing between the Veterans Administration and the military services is relatively unique. We would welcome the opportunity to build on and expand such sharing through incentives.

While we have focused primarily on the very broad issues raised by this bill, we have several concerns which should not escape attention. One is the provision that would appear to make sharing arrangements operative upon agreement by facility directors, subject only to subsequent revocation after submission to agency headquarters. We believe this provision does not allow sufficient review at the department level which we consider essential in light of the magnitude of the expenditures involved and the possible impact of such agreements beyond the local facility itself. We have made considerable progress in streamlining the process of reviewing sharing agreements and do not believe such a provision is prudent or needed.

Secondly, rather than directing providing agencies to prepare extensive reports to a series of committees, we commend to your attention the model of VA's sharing law which, in 38 U.S.C., section 5057, calls simply for a report to Congress on VA's sharing activities.

As a final point, if establishment of a Federal Interagency Health Resources Committee is to be mandated, we recommend that your committee give careful consideration to the inclusion of all the federal agencies now represented on the Federal Health Resources Sharing Committee and that the bill identify its composition as being the chief medical officers of providing agencies representing the respective agency heads.

There are a number of other issues in S. 2958, e.g., reimbursement procedures, personnel ceiling exemptions, which we propose to address in a more detailed report on the bill and which we would like to discuss further with the committee in an effort to improve S. 2958.

We favor the principle of interagency sharing of medical resources. Such authority would enhance federal providers' abilities to meet their missions in a cost-effective manner. With suitable changes, and clarification to insure the permissive nature of access, we would be pleased to support this bill.

Mr. Chairman, this completes my statement. I will be pleased to answer any questions you or members of the committee may have.

QUESTIONS FOR THE VETERANS ADMINISTRATION

(Dr. Donald Custis)

1. What are the current plans for VA in FY 1981-1984 to (a) build new hospitals and clinics, or (b) renovate existing facilities?

ANSWER: I am attaching a copy of the Veterans Administration's FY 1981-85 Five-Year Medical Facility Construction Plan. In accordance with the provisions of PL 96-22, section 5007, the Veterans Administration provides this plan and a prioritized listing of the medical centers most in need of construction, replacement or major modernization to the House and Senate Veterans Affairs Committees.

2. What example(s) can you cite from the last few years on what is planned through FY 1984 in which the VA used or will use DOD facilities or equipment at no cost as permitted by 38 USC section 5011?

ANSWER: Although we expect that there exist several such arrangements between facility directors in the field, since such arrangements involve no cost, they are left to the discretion of local facility management at our 172 medical centers across the country. There has been no need to develop reporting systems to monitor this activity. Accordingly, we are unable to provide specific examples.

3. a. Why would the VA insist on having sharing arrangements entered into under authority of the S.2958 provisions be operative only after review by Central Office headquarters officials.

b. On what basis could a sharing arrangement be disapproved?

c. What impact would such arrangements have beyond the local facility itself?

ANSWER: a. The Veterans Administration's Department of Medicine and Surgery medical care system is organized into 6 geographic regions and 28 medical districts. One of the reasons for this organizational structure is to facilitate the orderly planning for the most efficient and effective use of the VA's medical care resources. Decisions on how and where to place medical resources to allow for the most equitable distribution and consistency with systemwide workload demands can best be made from the vantage point of higher levels of management. While we respect local priorities, because of the limited resources and budget constraints placed on the health care system, we must weigh those priorities with others in the same medical district and other medical districts in this same regions. The provision that would make sharing arrangements operative upon agreement by the facility directors, subject only to subsequent revocation after submission to agency headquarters, does not allow sufficient review at the Department level which we consider essential in light of the magnitude of the expenditures involved and the possible impact of such agreements beyond the local facility itself.

b. A sharing arrangement could be disapproved if it was determined to be not beneficial to the federal government, if Congress denied VA requests for funds or personnel ceiling to support the proposed sharing arrangement, or if competition for resources proved to be detrimental to serving the VA's primary beneficiary.

c. Sharing arrangements could have impact beyond the local facility providing the arrangement if a facility was approved to provide medical services requiring personnel over and above the approved ceiling and such personnel were hired. A subsequent decision to terminate the sharing agreement would cause a surplus of personnel and the possibility of the need for reduction in force. Likewise, the construction of facilities for sharing purposes or the acquisition of equipment for sharing purposes could lead to excess capacity if such sharing arrangements were terminated. These situations would impact not only on the local facility's budget and staffing levels but on the system as a whole.

4. Wouldn't the heads of the agencies (VA and DOD) have a better feel for the competing needs within their respective agencies rather than just the medical needs. Also, with the heads of the agencies responsible for the implementation of the bill's provisions, wouldn't it be easier to obtain, reallocate, or request additional funds or positions, if needed, from the Congress to make better use of our federal sector's medical resources?

ANSWER: While there is much to recommend in designating heads of provider agencies as members of the proposed Federal Interagency Health Resources Committee, our concern is that the actual composition of this committee, by delegation or otherwise, reflect the expertise and responsibility of the agencies' chief medical officers. Identifying the committee's composition as including those officers as representatives of the respective agency heads would ensure this in a manner that S. 2958 does not.

5. Could you briefly describe (a) the VA's administrative efforts to expand sharing with other federal agencies and (b) which of the many obstacles have been overcome through these efforts?

ANSWER: Improvements have occurred in the last few years in the administration of the program for sharing of specialized medical resources. These improvements include more awareness at the Central Office level and also at field facilities of the availability of interagency resources, the reduction in processing time for gaining sharing agreement approval and also increased guidance to field activities on the mechanics of sharing medical resources. In addition, the Veterans Administration has played an important role in developing greater coordination in health services planning by federal agencies through its role on the Federal Health Resources Sharing Committee (FHRSC). This committee has made substantive progress in developing guidelines and criteria for assessing and justifying the need for an appropriate location of particular specialized medical services; in developing program utilization standards; and in actively exploring sharing opportunities in specific geographic areas. One subcommittee of the FHRSC is currently developing a standard format for use by each agency in obtaining a current listing of all federal sharing arrangements. A computerized, consolidated listing of all interagency sharing agreements is in the final stage of preparation. The Veterans

Administration has had authority in title 38 USC section 5053 to share specialized medical resources which because of cost, limited availability, or unusual nature, are either unique in the medical community or are subject to maximum utilization only through mutual use. We have been advised that the military medical services lack specific legislative authority to provide medical care to beneficiaries of other agencies under sharing arrangements and we understand that the provisions of S.2958 will provide this authority and thereby remove many obstacles.

6. Is it reasonable to expect that DOD beneficiaries would have a higher priority for care if S. 2958 were enacted at the expense of the non-veterans currently provided care under P.L. 89-795 authority? If not, why not?

ANSWER: The priorities for veteran beneficiary care are now well established and outlined in section 612 of title 38 USC. The Congress has not established any priorities for care related to the authority in section 5053 to share specialized medical resources. Our current authority allows us to share excess capacity which has been justified on the basis of veterans care, but which is not utilized to its maximum effective capacity. Under section 5053, the VA has authority only to share specialized medical resources with other community hospitals, or medical installations having hospital facilities or organ banks, blood banks or similar institutions, or medical schools or clinics in the medical community. The determination of whether beneficiaries of the community facility or the federal facility under these respective authorities would have priority for care would depend on the terms of the sharing agreements in question.

7. Under what authority is this sharing arrangement involving Wright-Patterson AFB being formulated? Are there any remaining obstacles which must be overcome before this sharing arrangement is fully implemented? What reimbursement rate was mutually agreed upon? How does this rate compare to other fees for the same service in the nearby medical community?

ANSWER: Actions thus far relating to the subject sharing arrangement have been the result of recommendations offered by the Federal Health Resources Sharing Committee. Formulation of a formal sharing arrangement is still in the discussion phase between officials of the VAMC Dayton and the Wright-Patterson AFMC. At the present time, the reimbursement rate must be based on the authority provided by 31 USC 686 (Economy Act) using DOD interagency inpatient rate of $250 per day. The cardiac catheterization procedure requires a stay of three inpatient days at a cost of $750 per patient. Other expenses added to the inpatient rate would include transportation cost for the 30-mile round trip and salary cost of an attendant. The average cost for the same service in community facilities would be approximately $600.

Obstacles which must be overcome before this sharing arrangement can be finalized include the following:

a. The AFMC must make provision for the patient care, teaching and research missions of the VAMC Cardiology Service. To accomplish this the VA considers it vitally important that one professional team be established consisting of cardiologists from both medical centers. The Air Force is reluctant to agree to this.

b. The GAO has recommended that the VA excess its laboratory equipment. This is impractical because the equipment is still required for the performance of other kinds of angiographic studies. This workload cannot now be assumed by the AFMC.

(Subsequently, the Veterans Administration
furnished the following information concerning the
VAMC North Chicago and Great Lakes Naval Hospital
Facilities)

1. Declining Workload at Great Lakes Naval Hospital:

We feel it inappropriate for our Agency to comment on declining patient load at the Great Lakes Naval facility.

2. Costs Associated with Upgrading Acute Care Facilities at VAMC North Chicago Over Past Six Years:

Construction - $3,950,000

Equipment - $ 5,376,000

3. Costs Associated with Upgrading Intermediate Care Facilities Over Past Six Years:

Construction - $4,342,000

Equipment - $344,000

4. Projected Costs for Upgrading Acute and Intermediate Care Facilities Over Next Five Years:

Acute - $5,090,000 (includes $1.2 million for air conditioning).

Intermediate - $4,709,000 (includes $2.9 million for air conditioning).

5. Status of Sharing:

The Navy and the Veterans Administration have shared over the years. The very property the VA is on was purchased by the Navy in 1925 and given to the VA. Over the years the VA has negotiated agreements for the Navy to provide fire protection, removal of trash, water and many other such services. We combined steam requirements and the VA transferred 15 employees, and over $1,000,000 to the Navy. Community sharing of medical services had also been negotiated. We had agreements to treat active duty personnel at our medical center to include inpatient and outpatient services, especially in specialty areas of neurology, neurosurgery, urology, ENT and ophthalmology. We also provide psychiatric examinations, orthopedic examinations and treatment. We have an agreement in deep radiation therapy with the Navy providing the equipment, the VA the physicians. The Navy provides the VA with some blood products. At one time, we moved our entire surgery service into the Navy hospital while VA had construction problems. We have had negotiations over several of the Navy's buildings over the last six years, including the hospital for medical use. Most of these have proved unsuccessful for many reasons. Among them include: Navy needs for beds for wartime use, transportation problems, mission problems and funding problems.

We must realize the Navy hospital would have to be modified before veterans could be moved in. The hospital has over 450 beds of its 666 total in 38 to 40 bed open wards. To meet VA criteria for patient privacy would require several million dollars for alterations. The hospital is not a teaching facility and has no research. It is our understanding that these may be among the reasons for the loss of physicians there. If the hospital were modified for patient privacy, the bed capacity would be around 500 beds. If we could expect an 85 percent occupancy, the resultant average daily census would be 425. The Navy currently has a census of around 125 and by pulling in CHAMPUS patients, this could grow to around 200. This would leave 225 beds for VA use. Only our acute care patients could move into these beds, as our acute census is about 125. This bed count would not accommodate our current workload of nearly 400 intermediate care patients. Therefore, any costs we have provided for intermediate care would be less meaningful in any cost analysis. Not only would the Navy have to spend a large sum to convert its facility, but the VA would have to spend around $2 million to convert its acute medical building (building #133) to a psychiatric setting. We would expect any cost saving would have to be realized in reduced recurring funds over the years.

Senator Percy. Thank you very much, Dr. Custis.

I would like to acknowledge Alan Mertz, of my own staff, and the Governmental Affairs Committee for the outstanding work that has been done in this hearing and this legislation. We will continue to look forward to working with you closely as it evolves. The potential is very great indeed.

Thank you very kindly.

The hearings are adjourned.

[Whereupon, at 11 a.m., the committee recessed, to reconvene subject to the call of the Chair.]

ADDITIONAL MATERIAL FOR THE RECORD FOLLOWS

96TH CONGRESS
2D SESSION

S. 2958

To ensure the development and implementation of policies and procedures to encourage the Veterans' Administration and the Department of Defense to cooperate in the efficient and effective use of Federal medical resources, and for other purposes.

IN THE SENATE OF THE UNITED STATES

JULY 23 (legislative day, JUNE 12), 1980

Mr. PERCY (for himself and Mr. PROXMIRE) introduced the following bill; which was read twice and referred to the Committee on Governmental Affairs

---

A BILL

To ensure the development and implementation of policies and procedures to encourage the Veterans' Administration and the Department of Defense to cooperate in the efficient and effective use of Federal medical resources, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That this Act may be cited as the "Federal Interagency Medical Resources Sharing and Coordination Act of 1980".

FINDINGS AND PURPOSES

SEC. 2. (a) The Congress finds that—

(1) coordination among Federal agencies in the use of Federal medical resources would minimize duplication and underutilization of Federal direct health care facilities;

(2) greater interagency sharing of medical resources between the Veterans' Administration and the Department of Defense may be achieved without a detrimental effect on each agency's primary beneficiaries;

(3) currently there are not adequate incentives in the various Federal direct health care delivery systems to encourage maximum interagency use of Federal medical resources; and

(4) the Veterans' Administration and the Department of Defense should, to the extent feasible within each agency's responsibilities, share medical resources and increase the coordination of medical care.

(b) It is the purpose of this Act to clarify and expand the authority of the Veterans' Administration and the Department of Defense as direct health care providers in order to facilitate Federal interagency sharing of medical care and medical care support resources.

DEFINITIONS

SEC. 3. As used in this Act, the term—

(1) "direct health care" means any health care provided to an eligible beneficiary in a facility operated

by the United States Government, including inpatient care and any type of outpatient treatment, testing, or examination;

(2) "beneficiary" means any individual who is entitled by law to direct health care furnished by the Veterans' Administration or the Department of Defense;

(3) "providing agency" means the Veterans' Administration or the Department of Defense;

(4) "primary beneficiary" means an individual who is specifically entitled by law to direct health care in the facilities of a particular providing agency;

(5) "negotiated cost" means the cost determined by local hospital officials on a medical service-by-service, hospital-by-hospital basis to be an equitable and consistent charge for the services provided; and

(6) "medical resource" means medical care and medical care support resources.

INTERAGENCY FEDERAL MEDICAL CARE COORDINATION

SEC. 4. (a) There is hereby established a Federal Interagency Health Resources Committee (hereinafter referred to as the "Committee"). The Committee shall be composed of the Secretary of Defense and the Administrator of Veterans' Affairs. In order to establish policies applicable to the Veterans' Administration and the Department of Defense as Federal direct health care providers with regard to interagency sharing of medical resources, the Committee shall, notwithstanding any other Federal law relating to interagency sharing of medical resources, undertake the following:

(1) Assess the opportunities for interagency sharing of existing health resources between the Veterans' Administration and the Department of Defense.

(2) Remain continuously apprised of the planning of any additional Veterans' Administration or Department of Defense medical facilities, including the location of new facilities and the acquisition of major new medical equipment, with regard to the impact of such plans on opportunities for interagency sharing.

(3) Review existing Veterans' Administration and Department of Defense direct health care capabilities, including support and administrative services, to identify sharing opportunities that will not adversely affect the quality of, or the established priority of, care provided.

(4) Prescribe policies and procedures designed to maximize the interagency sharing of Veterans' Administration and the Department of Defense medical facilities and services.

(5) Coordinate the establishment of uniform interagency health care policies and procedures for provid-

ing agencies and monitor the implementation of such policies and procedures, including policies and procedures for coordinated planning for future development of each agency's Federal direct health care delivery system.

(6) Prescribe guidelines, within 180 days after the date of the enactment of this Act, to directors and commanding officers of health care facilities within the Veterans' Administration and the Department of Defense for the sharing of medical resources by such health care facilities. Such guidelines shall provide, consistent with the policies and procedures developed under this Act, for the following:

(A) The director or commanding officer of each health care facility within the jurisdiction of the Veterans' Administration and the Department of Defense shall, whenever possible, enter into interagency cooperative sharing arrangements with other health care facilities of such providing agencies. Under such arrangements, a beneficiary eligible for direct health care in one Federal agency's facility may receive medical care at a providing facility of the other agency.

(B) Services to be shared may include any medical resource.

(C) Medical resources to be shared shall be negotiated by the directors or commanding officers of the health care facilities entering into an arrangement.

(D) The availability of hospital or medical care to beneficiaries of an agency other than the providing agency shall be on a referral basis, and shall not, as determined by the directors or commanding officers participating in such arrangements, adversely affect the quality of care and priority access for medical services of the providing agency's beneficiaries.

(E) Whenever a beneficiary receives medical services from a providing agency other than the particular providing agency for which such beneficiary is a primary beneficiary, such providing agency shall be reimbursed based on negotiated costs as agreed by the directors or commanding officers of the participating health care facilities.

(F) Reimbursement shall be credited when received by the providing agency to the specific facility that provided the medical service. Funds received as reimbursement for the provision of shared services may be obligated for the fiscal year following the fiscal year in which the medical service was provided.

(G) Sharing arrangements shall be operative upon agreement of the directors or commanding officers entering into such arrangements unless disapproved upon submission to each agency headquarters.

(H) Nothing in this Act shall be construed to preclude sharing of medical resources pursuant to any other law among all Federal direct health care providers.

(b) The joint responsibilities of the Administrator of Veterans' Affairs and the Secretary of Defense under this Act with regard to uniform direct health care shall not be construed to alter any single agency's responsibilities with regard to the provision of medical services provided by law.

(c) Providing agencies may request from Congress (1) relief from applicable personnel ceilings or other restrictions, and (2) funds to acquire the resources necessary to treat beneficiaries of other providing agencies. A providing agency shall specifically substantiate any such request.

(d) The Veterans' Administration and the Department of Defense shall report to the Committees on Governmental Affairs, Veterans' Affairs, and Armed Services of the Senate and the Committees on Government Operations, Veterans'

Affairs, and Armed Services of the House of Representatives on the date one year after the date of the enactment of this Act, and annually thereafter, and to the Committees on Appropriations of the Senate and the House of Representatives upon the presentation of such agency's appropriations request each fiscal year, with regard to—

(1) the guidelines prescribed pursuant to subsection (a)(6);

(2) the interagency sharing arrangements entered into by health care facilities of such providing agency;

(3) each providing agency's activities pursuant to cooperative interagency sharing arrangements;

(4) other interagency activities directed toward maximizing the efficient use of Federal health resources during the preceding fiscal year;

(5) the progress of Federal interagency medical resource sharing;

(6) the interagency coordination of Federal health resources planning; and

(7) other major Federal activities to increase interagency sharing of Federal medical resources.

Legislative recommendations may be included in such reports.

COMPTROLLER GENERAL OF THE UNITED STATES
WASHINGTON, D.C. 20548

B-133044

To the President of the Senate and the
Speaker of the House of Representatives

This report discusses actions needed by the Congress and the executive branch to make better use of Federal medical resources and remove obstacles to interagency sharing.

Our review was made at the request of the Chairman, House Committee on Appropriations, and pursuant to the Budget and Accounting Act, 1921 (31 U.S.C. 53), and the Accounting and Auditing Act of 1950 (31 U.S.C. 67).

We are sending copies of this report to the Director, Office of Management and Budget; the Secretaries of Defense and Health, Education, and Welfare; and the Administrator of Veterans Affairs.

ACTING Comptroller General
of the United States

COMPTROLLER GENERAL'S
REPORT TO THE CONGRESS

LEGISLATION NEEDED TO ENCOURAGE BETTER USE OF FEDERAL MEDICAL RESOURCES AND REMOVE OBSTACLES TO INTERAGENCY SHARING

DIGEST

The Congress has expressed its desire for greater sharing of the Nation's medical resources by enacting several laws to encourage regional cooperation in the health care community. However, Federal agencies' participation in regional health planning groups established as a result of these laws has, for the most part, been only advisory.

No interaction is required between Federal agencies responsible for the direct delivery of health care. Moreover, no laws clearly require Federal interagency sharing, although several permit Federal health facilities to share their capabilities with other agencies.

GAO studied the direct health care delivery activities of the Department of Defense (DOD), the Veterans Administration (VA), and the Department of Health, Education, and Welfare's (HEW's) Public Health Service to identify (1) opportunities for Federal health care providers to share their resources and (2) legislative, administrative, and other obstacles which preclude or inhibit sharing. Each is responsible for providing medical care to specified categories of beneficiaries.

The Office of Management and Budget works with the agencies to improve the planning and coordination of Federal health programs, most often through its annual budget reviews.

In fiscal year 1977, DOD, VA, and HEW collectively spent over $6 billion to provide medical care directly to eligible Federal beneficiaries and over $700 million for medical care provided to eligible beneficiaries in the non-Federal sector. Recently, representatives of the three agencies met to

Tear Sheet. Upon removal, the report cover date should be noted hereon.

begin planning for increasing interagency sharing. An interagency Federal Health Resources Sharing Committee has been established. (See p. 10 and apps. II and III.)

Numerous opportunities for increased interagency sharing either were not considered as opportunities by the agencies involved, had been pursued but abandoned, or had been only partially successful. (See app. IV.)

In most instances the following obstacles precluded attempts by or discouraged local Federal officials from completing satisfactory interagency sharing arrangements.

--The absence of a specific legislative mandate for interagency sharing and a lack of adequate headquarters guidance on how to share. (See p. 11.)

--Restrictive agency regulations, policies, and procedures. (See p. 14.)

--Inconsistent and unequal methods for agencies to be reimbursed for services rendered to other agencies' beneficiaries. (See p. 23.)

Attempts to share, whether started at the local Federal hospital level (including clinics) or by an interagency group at the department level, such as the Federal Health Resources Sharing Committee, will be hindered by the same obstacles.

Existing legislation is subject to various interpretations and/or permits only certain types of resources to be shared. This makes it difficult for agencies to use such legislation to increase interagency sharing. Frequently Federal officials do not know what the specific groundrules are, and little substantive direction has been provided to local Federal hospitals concerning interagency sharing problems and questions.

Eliminating legislative and administrative obstacles and implementing a structured

Federal interagency sharing program would be advantageous to both the Federal Government and its health care beneficiaries.

A key factor is enacting legislation to direct interagency sharing whenever appropriate and encourage the establishment of uniform Government-wide implementing procedures. Such legislation should encourage individual initiative without affecting any Federal agency's organizational or command structures. It should also give increased management options to local Federal medical officials to make the best use of the Nation's medical resources.

RECOMMENDATIONS TO AGENCIES

The Secretaries of Defense and Health, Education, and Welfare and the Administrator of Veterans Affairs should jointly direct the Federal Health Resources Sharing Committee to expeditiously seek workable solutions to the administrative obstacles within each agency which impede sharing, and report individually on an annual basis to the congressional appropriations committees on the progress being made in implementing an effective sharing program. (See p. 30.)

The Director, Office of Management and Budget, should establish a management group within the existing Office of Management and Budget organizational structure to work with DOD, HEW, and VA to better coordinate the development of an effective Federal sharing program. The group should work closely with the Federal Health Resources Sharing Committee and with the Office of Management and Budget officials responsible for reviewing budget requests for Federal health care delivery activities in order to foster increased interagency sharing. (See p. 30.)

RECOMMENDATIONS TO THE CONGRESS

The Congress should enact legislation to establish a greatly expanded and cost-effective interagency sharing program. Specifically this legislation should:

- --Establish a Federal policy that directs interagency sharing when appropriate.
- --Authorize each Federal direct health care provider to accept all categories of eligible beneficiaries on a referral basis when advantageous to the Government and care of primary beneficiaries would not be adversely affected.
- --Eliminate all restrictions on the types of medical services which can be shared.
- --Authorize Federal field hospital managers to enter into sharing arrangements, subject to headquarters veto only if judged not in the best interests of the Government.
- --Authorize expansion of services as necessary to use Federal medical resources in the most cost-effective manner.
- --Establish a policy requiring full use of available nearby Federal medical resources before using civilian or distant Federal medical resources.
- --Authorize the establishment of a method of reimbursement under which the providing Federal hospital would receive any revenues received to offset any expenses incurred.
- --Assign to the Office of Management and Budget the responsibility to (1) coordinate the implementation of an effective interagency Federal medical resources sharing program and (2) report annually to the Congress concerning the progress being made toward increased sharing of these resources. (See p. 30.)

AGENCY COMMENTS

DOD and HEW generally agreed with GAO's conclusions and recommendations. VA did not. The Office of Management and Budget did not take a position on the legislative recommendations, but disagreed with GAO's recommendation regarding the designation of a group to work with the Federal agencies to coordinate the development of an effective interagency sharing program.

GAO's evaluation of the agencies' comments is on pages 31 through 38.

Contents

Page

DIGEST i

CHAPTER

1 INTRODUCTION 1
Major Federal health care delivery systems 1
Legislative authorities for sharing Federal medical resources 3
OMB oversight of Federal health care delivery activities 8

2 OBSTACLES TO SHARING 10
Lack of specific legislative authority and adequate headquarters guidance 11
Restrictive regulations, policies, and procedures 14
Inconsistent and unequal reimbursement methods 23

3 CONCLUSIONS, RECOMMENDATIONS, AND AGENCY COMMENTS 28
Conclusions 28
Recommendations to DOD, HEW, and VA 30
Recommendations to OMB 30
Recommendations to the Congress 30
Evaluation of agency comments 31

4 SCOPE OF REVIEW 39
Hospitals and clinics reviewed 39

APPENDIX

I Request letter, dated January 10, 1977, from the Chairman, House Committee on Appropriations 42

II Prior studies indicate continuous concern over management and proper use of Federal medical resources 44

APPENDIX Page

III Federal agencies' efforts to better use medical resources 58

IV Case studies of selected opportunities--and related obstacles--to interagency sharing 64

V Proposed legislation for assuring the development of policies and procedures to make more efficient and effective use of existing Federal medical resources 147

VI Letter dated April 5, 1978, from DOD 152

VII Letter dated April 17, 1978, from HEW 159

VIII Letter dated April 18, 1978, from VA 163

IX Letter dated March 21, 1978, from OMB 169

X Principal officials responsible for administering activities discussed in this report 170

ABBREVIATIONS

CHAMPUS	Civilian Health and Medical Program of the Uniformed Services
CHAMPVA	Civilian Health and Medical Program of the Veterans Administration
DOD	Department of Defense
GAO	General Accounting Office
HEW	Department of Health, Education, and Welfare
OMB	Office of Management and Budget
PHS	Public Health Service
VA	Veterans Administration

CHAPTER 1

INTRODUCTION

Over the years, increasing concern has been expressed in the Congress and elsewhere over the rapidly increasing costs of medical care in the Nation. As in the private sector, Federal agencies' costs to provide health care directly to eligible beneficiaries have continued to rise, and substantial efforts have been made to explore ways of reducing these costs without adversely affecting the quality of care.

The Chairman, House Appropriations Committee, in January 1977 asked us to identify (1) opportunities for Federal health care providers to share their resources and (2) legislative, administrative, and other obstacles which may preclude sharing. The Chairman stated that the Committee was particularly interested in our recommendations to overcome these obstacles.

In response we visited or contacted officials at 50 Federal medical facilities in several areas of the United States and at the headquarters offices of the Federal agencies having major responsibilities for providing health care directly to beneficiaries. Because we focused on identifying obstacles to sharing and ways to overcome them, we did not attempt to identify all sharing opportunities which may exist in the geographic areas reviewed. The scope of our review is more fully discussed in chapter 4.

MAJOR FEDERAL HEALTH CARE DELIVERY SYSTEMS

The Department of Defense (DOD), the Veterans Administration (VA), and the Department of Health, Education, and Welfare (HEW) have the major responsibilities for providing health care directly to eligible Federal beneficiaries. [1] Although we reviewed only selected direct health care activities of these agencies, our comments and recommendations should apply to all Federal direct health care providers.

---

[1] We concentrated on HEW's Public Health Service hospital system (including clinics). However, HEW's Indian Health Service has significant responsibilities for meeting the health needs of Indians. Other Federal agencies also provide health care to specified segments of the population. For example, the Justice Department's Bureau of Prisons provides health care--with the assistance of Public Health Service physicians--to prison inmates.

DOD health care beneficiaries include active duty military members and, when space, facilities, and staff are available, their dependents, retirees, and dependents of retired and deceased military members. DOD's health care delivery system is composed of three separate systems administered by the Surgeons General of the Army, Navy, and Air Force. VA health care beneficiaries include veterans with service-connected disabilities, those with non-service-connected disabilities who meet other eligibility criteria, and dependents and survivors of certain veterans. HEW's Public Health Service (PHS) hospital system cares for several categories of beneficiaries, including American seamen and active duty members of the Coast Guard and PHS. The following table illustrates the magnitude of these agencies' medical operations within the continental United States.

Hospital and clinic system	Number of Hospitals	Number of Clinics	Estimated expenditures for hospitals and clinics (FY 1977)	Total FY 1977 Hospital admissions	Total FY 1977 Outpatient visits
			(000,000 omitted)	(000 omitted)	
DOD	129	203	$2,500	848	48,140
VA	171	219	3,663	1,270	14,675
PHS	9	26	115	34	1,733
Total	309	448	$6,278	2,152	64,548

In addition, the Congress has appropriated substantial amounts to the agencies to pay for medical care for their beneficiaries at other than their own facilities. For example, in fiscal year 1977, the Congress appropriated about $566 million for DOD to provide for medical services to beneficiaries under the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) 1/ and about $28 million for VA to provide for services to certain beneficiaries under

---

1/CHAMPUS provides medical care from civilian sources for dependents of active members, retirees and their dependents, and the dependents of deceased members. "Uniformed services" include the Army, Navy, Air Force, Marine Corps, Coast Guard, and commissioned corps of PHS and the National Oceanic and Atmospheric Administration.

the Civilian Health and Medical Program of the Veterans Administration (CHAMPVA). 1/ In addition, DOD, VA and PHS contract with civilian facilities for hospital services. In fiscal year 1977 these agencies expected to spend about $128 million for such services.

LEGISLATIVE AUTHORITIES FOR SHARING FEDERAL MEDICAL RESOURCES

Congressional desire for greater sharing was demonstrated in the Heart Disease, Cancer, and Stroke Amendments of 1965 (42 U.S.C. 299-299j) and the Comprehensive Health Planning and Public Health Service Amendments of 1966 (42 U.S.C. 246). The purpose of the former legislation was to improve the level of health care in the Nation by increasing regional cooperation. The Comprehensive Health Planning and Public Health Service Amendments of 1966 authorized the creation of organizations to encourage cooperation between governmental or nongovernmental agencies, organizations, and groups concerned with health services, facilities, or manpower.

The most recent major legislation containing congressional intent concerning sharing was contained in the National Health Planning and Resources Development Act of 1974 (Public Law 93-641, 42 U.S.C. 300 et seq.). This legislation requires non-Federal hospitals to coordinate and plan the use of their medical resources in order to improve the quality of care and avoid duplication of resources. Although VA's participation in local health planning was provided for in the act and other Federal agencies were included in advisory capacities, no interaction between the VA, DOD, and HEW health systems was required.

Various laws permit Federal interagency sharing. No laws, however, clearly require interagency sharing. The authorities under which each agency reviewed is permitted to share, the authorities for each agency to secure services from non-Federal health providers, and Federal reimbursement arrangements are shown in the tables on the next three pages.

1/CHAMPVA provides care for the spouses and children of veterans who died or were totally disabled as a result of a service-connected disability.

Laws--and Reimbursement Rates--Authorizing Federal and Non-Federal Medical Resources To Be Shared With DOD (As of April 1978)

Provider		
VA	PHS	Non-Federal
31 U.S.C. 686 (Economy Act)--broad base for interagency sharing	31 U.S.C. 686 (Economy Act)--broad base for interagency sharing	10 U.S.C. 2301 *et seq.*--DOD general contract authority
Reimbursement: actual cost using VA interagency rates ($138 per day--inpatient, $41 per visit--outpatient)	Reimbursement: actual cost using PHS interagency rates ($142 per day--inpatient, $39 per visit--outpatient)	Reimbursement: negotiable
38 U.S.C. 5053--sharing specialized medical resources only	42 U.S.C. 254a--sharing specialized medical resources only	10 U.S.C. 1079, 1083, 1086--(CHAMPUS)--care for military retirees and dependents
Reimbursement: full cost (including normal depreciation and amortization of equipment)	Reimbursement: reasonable cost (including normal depreciation and amortization of equipment)	Reimbursement: 80 percent of provider's charges
38 U.S.C. 5003--facility and equipment sharing only	10 U.S.C. 1074, 1076--active duty military, retirees, and dependents	
Reimbursement: none required	Reimbursement: PHS interagency rates	
10 U.S.C. 1074(b)--care for certain military retirees only		
Reimbursement: VA interagency rates		

Laws--and Reimbursement Rates--Authorizing Federal and Non-Federal Medical Resources To Be Shared With VA (As of April 1978)

Provider		
DOD	**PHS**	**Non-Federal**
31 U.S.C. 686 (Economy Act)--broad base for interagency sharing	31 U.S.C. 686 (Economy Act)--broad base for interagency sharing	38 U.S.C. 5053--sharing specialized medical resources only
Reimbursement: actual cost using DOD interagency rates ($206 per day--inpatient, $20 per visit--outpatient)	Reimbursement: actual cost using PHS interagency rates	Reimbursement: full cost (including normal depreciation and amortization of equipment)
38 U.S.C. 5003--facility and equipment sharing only	42 U.S.C. 254a--sharing specialized medical resources only	38 U.S.C. 213--general contract authority
Reimbursement: none required	Reimbursement: reasonable cost (including normal depreciation and amortization of equipment)	Reimbursement: negotiable
38 U.S.C. 616--care for veterans if authorized by appropriation or other act	38 U.S.C. 616--care for veterans if authorized by appropriation or other act	38 U.S.C. 628--contract for care where VA facilities are "not feasibly available"
Reimbursement: DOD interagency rates	Reimbursement: PHS interagency rates	Reimbursement: negotiable
		38 U.S.C. 613--(CHAMPVA)--care for certain survivors and dependents of veterans
		Reimbursement: 75 percent of provider's charges

Laws--and Reimbursement Rates--Authorizing Federal and Non-Federal Resources To Be Shared With PHS (As of April 1978)

Provider		
DOD	VA	Non-Federal
31 U.S.C. 686 (Economy Act)--broad base for interagency sharing Reimbursement: actual cost using DOD interagency rates	31 U.S.C. 686 (Economy Act)--broad base for interagency sharing Reimbursement: actual cost using VA interagency rates	42 U.S.C. 254a--sharing specialized medical resources only Reimbursement: reasonable cost (including normal depreciation and amortization of equipment)
10 U.S.C. 1074, 1076--care of uniformed services beneficiaries Reimbursement: DOD interagency rates	38 U.S.C. 5053--sharing specialized medical resources only Reimbursement: full cost (including normal depreciation and amortization of equipment)	42 U.S.C. 249(e)--general contract authority Reimbursement: negotiable
	10 U.S.C. 1074(b)--care for certain retirees only Reimbursement: VA interagency rates	10 U.S.C. 1079, 1083, 1086--(CHAMPUS)--care for military retirees and dependents Reimbursement: 80 percent of provider's charges

The Economy Act, 31 U.S.C. 686, authorizes a Federal hospital 1/ to request the services of another Federal hospital. The act was designed to allow Federal agencies' resources to be used to capacity and avoid unnecessary duplication and overlap of activities. The statute is permissive, except for these limitations: (1) both hospitals must be Federal hospitals, (2) the supplier must be reimbursed on the basis of actual cost, and (3) the providing agency must be able to provide the service without increasing its resources. Patients can be admitted or transferred to hospitals other than those primarily charged with treating them, funds can be transferred from the requisitioning facility to the supplying facility, and staff from other agencies can be employed by the Federal hospital.

DOD

The Congress has expressed its desire for sharing of medical capabilities between military hospitals. Armed Forces hospitals are authorized to provide resources to other Armed Forces hospitals for treating active duty members and their dependents, certain former members and their dependents, and dependents of certain deceased former members. Transfers of funds between services is not required, and care for dependents and retirees is to be provided when space and other resources are available.

DOD hospitals are authorized to share facilities and equipment with VA under 38 U.S.C. 5003. In addition, they may provide medical services to certain veterans--under contract with VA--and emergency services to nonmilitary personnel. However, the Economy Act represents the only broad authority under which military hospitals may provide medical services to other agencies' beneficiaries. Unlike VA and PHS, DOD has no specific authorization to provide specialized medical services to other agencies' beneficiaries.

VA

VA, which administers the largest health care system under unified management in the Nation and uses a significant portion of the Nation's total health care resources, is authorized to share medical training resources and medical information resources. In addition to providing general

---

1/Throughout this report the term "hospital" is used to describe both hospitals and clinics, whether or not the clinics are attached to the hospitals.

authority for VA to share its resources with Federal agencies under the Economy Act, the Congress has given VA specific authority (38 U.S.C. 5053) to share "specialized medical resources" with other hospitals and clinics (Federal, State, local) and medical schools.

Although fairly broad in scope, 38 U.S.C. 5053 does not give VA unlimited sharing authority. The most important limitation is that the statute covers only "specialized medical resources." These are defined as medical resources (whether equipment, space, or personnel) which, because of cost, limited availability, or unusual nature, either are unique in the medical community or can be fully used only through mutual use. Secondly, VA must be reimbursed the full cost of services. Finally, sharing arrangements negotiated under this authority may not decrease the quality of care provided eligible veterans. Beyond these restrictions, the statute is permissive. It does not restrict fund transfers, patient transfers, or staff mobility except insofar as these are indirectly affected by the above limitations.

VA facilities may also share equipment and facilities at no charge with DOD under 38 U.S.C. 5003. However, this statute does not provide for sharing medical services.

PHS

The Congress has expressed its desire for greater sharing involving PHS hospitals by enacting certain sharing legislation and during consideration of various bills. The principal concern has been to decrease needless duplication and to increase the quality of care provided in both PHS hospitals and non-PHS hospitals.

Like VA and DOD, PHS is authorized under the Economy Act to furnish facilities and services to other Federal agencies on a reimbursable basis. In addition, PHS is authorized by 42 U.S.C. 254a to share training and research resources, on a reimbursable basis, with medical schools and local agencies and to share specialized health resources, on a reimbursable basis, with hospitals and other health care facilities.

OMB OVERSIGHT OF FEDERAL HEALTH CARE DELIVERY ACTIVITIES

The Office of Management and Budget's (OMB's) responsibilities include:

- --To help develop efficient coordinating mechanisms to implement Government activities and to expand interagency cooperation.

- --To keep the President informed concerning the extent of Federal agencies' program coordination and whether appropriations are expended by agencies in the most economical manner with the least possible overlapping and duplication of effort.

To fulfill these responsibilities in regard to Federal health resources, OMB works with DOD, VA, and PHS to improve planning and coordination of Federal health care activities. For the most part, OMB's contacts with Federal agencies concerning health delivery occur during annual budget reviews. However, it has performed--with the assistance of these agencies--major studies of selected segments of the Federal health care delivery system. Also a recent revision to OMB Circular No. A-95 requires evidence of Federal agencies' coordination efforts with local health planning authorities before direct Federal medical construction projects or major equipment purchases will be approved.

In April 1977 the President signed the Reorganization Act of 1977 and directed the Director, OMB, to coordinate the examination of the entire Government structure to make it more responsive, efficient, and open. In a June 29, 1977, memorandum to executive agency heads, the President notified these officials that he had directed his Reorganization Project staff to begin a study of the organization and delivery of human services, which include health services. According to a Reorganization Project staff official, the study of the more than 100 Federal human services programs will be coordinated by a Human Resources group within the President's Reorganization Project and will draw upon the affected agencies for staff assistance. The group may study ways to streamline the Nation's Federal direct health care delivery systems.

CHAPTER 2

OBSTACLES TO SHARING

For nearly 30 years studies have pointed out the need for DOD, VA, and PHS to more effectively manage and operate their medical facilities. Several of these studies were conducted because of legislative requirements or because of congressional direction. Also we have, within the past several years, issued several reports on opportunities to make more appropriate use of Federal medical delivery capabilities by increasing either intraagency or interagency sharing. Many of the more important studies and our reports on this subject are discussed in appendix II.

Also the individual agencies reviewed have programs designed to make more efficient use of their own medical capabilities. For example, both DOD and VA have initiated programs to improve use of their health care resources within specified regions of the continental United States.

In mid-1977, at the invitation of the Assistant Secretary of Defense (Health Affairs), representatives of DOD, VA, and HEW met to initiate plans for increasing interagency sharing. As a result of this initiative, an interagency Federal Health Resource Sharing Committee was established. The Committee has been chartered by senior officials in each agency, organized itself, and met on several occasions. Two subcommittees have been established to formulate the basis for sharing decisions concerning cardiac catheterization and computerized tomography. Other subcommittees are being organized to address such issues as mobilization support and medical information systems. These subcommittees are expected to develop uniform standards to identify areas for potential sharing, and to present recommendations to the full Committee for sharing decisions. Appendix III discusses actions taken by the agencies to increase intraagency and interagency sharing.

We identified numerous additional opportunities for increased interagency sharing which were either (1) not considered as opportunities by the agencies involved, (2) pursued but then abandoned by the agencies, or (3) only partially successful. Appendix IV presents case studies of 20 of these opportunities and illustrates instances when the Government's costs of medical care for beneficiaries could be reduced without adversely affecting the care.

Reasons for the inabilities of officials at health facilities of one Federal agency to arrive at satisfactory sharing arrangements with those at facilities of a different agency varied considerably. In many instances the administrative difficulties encountered by these local officials apparently resulted from varied interpretations by the agencies concerning the extent of their sharing authority and the procedures to follow in arriving at sharing arrangements. In other instances local officials or their superiors were not inclined to consider sharing.

In most instances the following obstacles precluded attempts by or inhibited the efforts of local Federal officials to reach satisfactory interagency sharing arrangements.

--The absence of a specific legislative mandate for interagency sharing and a lack of adequate headquarters guidance on how to share.

--Restrictive agency regulations, policies, and procedures.

--Inconsistent and unequal reimbursement methods.

We believe that attempts to share, whether initiated at the local Federal hospital level or by an interagency group at the departmental level, such as the Federal Health Resources Sharing Committee, will be hindered by the same types of obstacles. The obstacles are discussed below.

LACK OF SPECIFIC LEGISLATIVE AUTHORITY AND ADEQUATE HEADQUARTERS GUIDANCE

Although numerous laws authorize (see pp. 4 to 6) beneficiaries from one Federal agency to be treated in another Federal agency's facility, none were explicit concerning what category of beneficiaries could be served. Of the laws, the Economy Act (31 U.S.C. 686) could probably best be used to share, but others, such as VA's sharing law (38 U.S.C. 5053) or PHS' sharing law (42 U.S.C. 254a) could also be used. However, these laws are interpreted differently by the agencies. Consequently, the extent of formal or informal sharing being conducted is minimal in terms of the total medical resources controlled by DOD, VA, and PHS. This condition prevails to some extent because the Congress has not enacted legislation which clearly specifies its expectations concerning interagency sharing.

The most recent major legislation containing congressional intent toward sharing the Nation's medical resources was the National Health Planning and Resources Development Act of 1974 (Public Law 93-641). Although VA participation was included to some extent in local health planning capacities and other Federal agencies (including VA) were included in advisory capacities, no interaction between the VA, DOD, and PHS health systems was required. However, the House committee report on the bill that became Public Law 93-641 expressed the hope that a review of proposed Federal health activities "outside the jurisdiction of the committee" would be undertaken by those responsible for the activities. To date, no such review has taken place.

In July 1976 House Conference Report No. 94-1314 provided policy guidance to DOD--which currently has no specific legislative sharing authority--on interagency sharing. The report directed DOD to:

--Develop policies to make maximum and cost-effective use of existing Federal hospitals.

--Coordinate the planning of future bed capacity with other Federal health care representatives.

While this guidance helped DOD plan, for example, the size of new military hospitals, the only specific legislative authority by which DOD could share remained the broad authority in the Economy Act enacted in 1915. This act does not relate only to health care activities; rather it permits one Federal agency to request any type of service from another. In this manner the act allows Federal medical resources to be fully used and unnecessary duplication of resources to be avoided. In essence, the Congress told DOD to share with other Federal agencies but gave no additional legislative authority to supplement the Economy Act to accomplish this task. More importantly, the Congress did not provide (1) legislation to require interagency sharing when appropriate or (2) uniform guidance necessary for sharing.

Because of this lack of a legislative mandate, Federal agencies have been unable or unwilling to establish an effective Federal interagency medical sharing program. Generally, agency officials believe that their individual health care systems were established to serve specific beneficiaries and to provide care for another Federal agency's beneficiaries would adversely affect their abilities to perform their primary missions. As a consequence, interagency sharing has been given a low priority within Federal agencies and, as might be expected, there are currently no uniform policies, regulations, or procedures. Therefore, guidance from the headquarters or command levels to hospitals or clinics attempting to enter into interagency sharing agreements generally lacks substantive direction.

In several examples a lack of guidance hindered sharing opportunities at the local hospital level. For example, in San Francisco, VA, through individual initiative, tried for almost 1-1/2 years to establish a sharing program with nearby DOD hospitals. (See app. IV, case study 7.) VA was particularly interested in obtaining services for its benficiaries at Letterman Army Medical Center. Letterman officials did not make any commitments to VA essentially because guidance on how to establish interagency sharing agreements was not available. Although Letterman requested guidance from the appropriate military medical coordinating staff in Washington, D.C., none was provided. Consequently, VA and Letterman did not exchange any services. VA could have saved about $100,000 annually if Letterman had provided services to meet part of VA's radiation therapy workload.

In another case, VA's Central Office did not respond to the Cheyenne VA Hospital on a proposed sharing agreement with the Warren Air Force Base Hospital. (See app. IV, case study 13.) Subsequently, no sharing agreement was ever finalized.

Also, in the Temple, Texas, area (see app. IV, case study 14) Darnall Army Hospital officials told VA that it was doubtful whether they were authorized to enter into a formal sharing agreement with VA. However, VA's authority (38 U.S.C. 5053) for entering into sharing agreements does provide that VA can buy services (although restricted to specialized medical resources) from, and/or sell specialized medical services to, other Federal hospitals.

The Army's Health Service Command, through which both Letterman and Darnall report, could not clarify the authorities and procedures for dealing with VA. The Chief of Plans and Operations said local Army officials do not pursue sharing opportunities with VA hospitals because they lack guidelines and procedures from DOD headquarters. The Chief of the Finance and Accounting Division said the Army did not have any regulation to correspond to VA's sharing authority, 38 U.S.C. 5053. Therefore, in his opinion, it was questionable whether Army hospital commanders are authorized to sign a VA sharing agreement. He also told us that it was uncertain whether the Economy Act authorized hospital commanders to negotiate or participate in sharing with VA.

The uncertainty and unresolved issues in these officials' statements typified those of most Federal agencies' headquarters officials with whom we discussed interagency sharing.

Because of the lack of uniform guidance, similar opportunities to share can have drastically different results. For example, on one hand, the Tucson VA Hospital had tried several times to enter into formal VA sharing agreements (38 U.S.C. 5053) with the Davis-Monthan Air Force Hospital. (See app. IV, case study 11.) Tucson VA's most recent effort to enter into a formal sharing agreement with Davis-Monthan took place in May 1974. Davis-Monthan officials decided that they weren't authorized to negotiate the type of agreement Tucson VA desired. They subsequently referred the proposed agreement to the Office of the Surgeon General, Strategic Air Command, to determine whether the proposed agreement was appropriate or required. A response, almost 3 months later, noted only that interagency rates were appropriate to be paid and did not address the type of agreement required. We could not determine why the local command had not followed up. No formal sharing agreement was finalized.

On the other hand, other VA and Air Force hospitals--Albuquerque VA Hospital and Kirtland Air Force Hospital--did enter into a formal VA sharing agreement similar to the one proposed by Tucson VA. (See app. IV, case study 12.) Air Force used the authority in its regulation concerning obtaining services to supplement its hospital's medical capabilities. Kirtland interpreted the regulation to include VA as a source for such services and did not receive any negative comments on the proposed agreement when it was submitted for review from higher authority--the Air Force Systems Command. Consequently, a sharing agreement was established, although further expansion into direct transfer and management of Air Force patients by VA may meet with certain regulatory restrictions.

RESTRICTIVE REGULATIONS, POLICIES, AND PROCEDURES

Several agency regulations, policies, and procedures, based on each agency's interpretation and implementation of existing legislation, inhibit interagency sharing. In several instances Federal hospitals could have shared services but refused because the treatment was not for emergency purposes or because beds, although available, had not been allocated in advance for use by another agency's beneficiaries.

We focused on DOD and VA regulations, policies, and procedures, since they are the largest Federal health care agencies. PHS' sharing authority, however, is restricted similarly to VA's.

DOD restrictions on treating VA beneficiaries

The most permissive interagency sharing authority which DOD could use to share its resources with other Federal agencies (e.g., VA) is the Economy Act. However, military regulations impose restrictions on providing services to VA beneficiaries under this authority.

For example, Army Regulation 40-3, section VIII, "Beneficiaries of Other Federal Agencies," paragraphs 4-29 and 4-30, place restrictions on VA beneficiaries being treated in Army facilities. Paragraph 4-29 covers eligibility of beneficiaries of other Federal agencies on a reimbursable basis at the expense of the referring agency under authority of the Economy Act. Paragraph 4-30, however, limits routine VA beneficiary care to Army facilities where beds have been allocated by prior agreement. Also admission to an Army facility within the continental United States in which bed allocations have not been made will be authorized only in emergencies. Navy and Air Force regulations also place similar restrictions on treating VA patients.

Also Army regulations regarding outpatient care for VA beneficiaries are not clear and are subject to interpretation. Army Regulation 40-3 states that outpatient care, other than in emergencies, must be authorized in advance. The Army Health Services Command's Chief of Patient Administration told us that this rule implies that it is permissible to furnish outpatient care to veterans, but it is only an implication subject to individual interpretation.

The chief also acknowledged that, at present, Army really has no specified mission to treat VA beneficiaries. For example, the "mission" argument was raised when VA requested radiation therapy from Madigan Army Medical Center. (See app. IV, case study 4.) Madigan responded by stating, in part, "* * * our next higher headquarters [Health Services Command] has not assigned us the mission of supporting the Veterans Administration in this matter." Consequently, VA was considering, at the time of our review, developing its own capability at an equipment cost alone of $500,000, although Madigan had the equipment.

This mission argument was raised in many of our discussions with DOD headquarters officials and in two other case studies. (See app. IV, case studies 13 and 18.) In most instances these officials believed in the sharing concept but thought that their medical facilities' missions would not permit such a radical departure from their current manner of operation.

VA restrictions on treating DOD beneficiaries

The Economy Act also permits VA to share its medical resources with other Federal agencies (e.g., DOD). However, VA interprets the Economy Act's authority rather narrowly and inconsistently.

A VA Central Office official in the Office of Regionalization and Sharing said dependents of active duty and retired military personnel could be treated in a VA hospital, if a formalized sharing agreement between a military hospital and VA were negotiated as specified in the VA sharing law (38 U.S.C. 5053). These same individuals would not be treated, according to this official, if the VA hospital had negotiated an interagency agreement under the Economy Act.

Another Central Office official told us that the Economy Act generally gives other agencies access to VA medical supplies and equipment. It has traditionally been used for sharing things rather than people or services, and VA normally does not exchange health services under the Economy Act. The official further explained that there were only a few--10 at August 1976--field station interagency agreements between VA hospitals and other Federal agencies for VA to provide items and services. One of these agreements had been established between the San Diego VA and Naval Hospitals (see app. IV, case study 10) for VA to provide cardiac catheterization resources. This agreement, under the Economy Act's authority, specified that active duty and retired military and their dependents, both men and women, would be eligible for cardiac catheterization, which is inconsistent with what the Office of Regionalization and Sharing official told us.

To obtain clarification about VA's interpretation of the Economy Act, we wrote to the Administrator of Veterans Affairs in May 1977. We used the Tucson VA Hospital and other Federal agencies in the greater Tucson area as examples of informal sharing apparently being done under the Economy Act. (See app. IV, case study 11.) We asked whether VA hospitals are authorized to provide medical services to all beneficiaries of other Federal agencies under the act, as

Tucson VA was apparently doing. We also asked VA to specify authorities under which it believed it could provide medical services to other agencies' beneficiaries if it had determined that the Economy Act's authority could not be used to provide such services. VA answered, in part, that:

> "VA hospitals are authorized to provide medical services to all beneficiaries of other Federal agencies under the so called cross-servicing statute 31 U.S.C. 686 (Economy Act), as well as VA Regulations 2045 and 6046. The provision of such services at a VA Hospital is dependent upon present capacity to provide such services without interference with the primary function, which is to deliver health care to veterans. The determination of capacity or capability to provide the requested service is administrative and may be expected to constantly fluctuate in direct relationship to veterans' care needs. Another consideration inherent in cross-servicing under 31 U.S.C. 686 is the staffing and equipment which would be needed; there is no legal authority to engage in cross-servicing if additional staffing and equipment are required. (Emphasis added.)
>
> "Our consideration for the overall medical needs of the veteran and retired and active duty service personnel also caused us to review medical services for their dependents--women and children--whom VA is neither staffed nor equipped to serve. The VA contracts for such care. Accordingly, the VA is not in a position to "cross-service" such needs, and the questions of authority to cross-service and the basis for recovery of costs thereunder become essentially moot."

VA's answer failed to address the primary issue of cross-servicing dependents by declaring VA is neither staffed nor equipped to serve them. However, as we pointed out in our letter to the Administrator, Tucson VA was servicing active duty and retired military members and their dependents. In other instances VA hospitals were accepting these types of beneficiaries. In no instances were these services, according to the VA hospital officials involved, being provided to the detriment of VA's primary beneficiaries.

In addition, VA regulations restrict other Federal agencies' beneficiaries from receiving routine medical care. For example, VA's Manual relating to "Medical Care Furnished Other Federal Agencies" discusses treating DOD beneficiaries in VA facilities. According to these regulations, active duty military personnel are approved for medical care if they require emergency hospital treatment or if they are potentially eligible as VA beneficiaries, because of forthcoming discharge from the Armed Forces. Outpatient treatment or examination in VA facilities must be authorized by the appropriate service departments. Retired members of the Armed Forces may receive hospital care or outpatient treatment on presentation of identification, when not otherwise eligible as a VA beneficiary. Dependents of active duty members will be given only emergency care. In addition, these regulations state that since VA does not have facilities for routine care and treatment of military dependents, such individuals will be transferred out of the VA system as soon as possible.

Restrictive VA sharing law

VA is permitted under its sharing law, 38 U.S.C. 5053, to share only specialized medical resources. The Chief Medical Director--VA's highest ranking medical official--determines what constitutes a specialized medical resource. Each resource considered for sharing is taken on its own merit in its particular geographical area. Therefore, a specialized medical resource in one area because of its cost, limited availability, or unusual nature may not be specialized and approved for sharing by the Chief Medical Director in another area.

Several VA hospital officials told us that the VA Central Office has been too restrictive in interpreting which resources may be shared under this authority and therefore sharing efforts are hindered. They believed that the law should be amended to allow sharing of every medical service, particularly between Federal facilities. Central Office officials also concluded that sharing restrictions need to be relaxed. They cited several examples when sharing proposals had been disapproved because of interpretations limiting types of services which may be shared. The disapproved proposals included sharing a therapeutic swimming pool, blood bank facility, psychiatric outpatient care, and outpatient alcoholic treatment. 1/

A VA official told us that "most" proposed sharing agreements are discussed with field hospital officials by telephone before any formal submission to VA's Central Office. Consequently, it is difficult to tell how many proposals were turned down because of the need to meet the specialized resource requirement.

For example, a sharing opportunity in the Seattle/Tacoma area was prohibited, in part, by this requirement. (See app. IV, case study 1.) Military dependents were receiving psychiatric outpatient services under CHAMPUS, even though the American Lake VA Hospital could have treated many of them. Madigan Army Medical Center and American Lake VA Hospital attempted to negotiate a sharing agreement for VA to provide services, but were restricted for two reasons: (1) VA's Central Office determined that psychiatric outpatient services were nonspecialized and could not be shared and (2) military dependents were not eligible for care in VA hospitals.

VA has tried to remove the specialized restriction by recommending legislative changes. The Assistant Chief Medical Director for Policy and Planning told us that a legislative proposal had been sent to OMB for consideration. The proposal recommends deleting the existing 38 U.S.C. 5053 section and substituting an entirely new authorization, which would expand VA's ability to share. VA's proposal incorporated the following principles:

--The specialized requirement would be dropped entirely. Instead, sharing, including support services with any Federal or non-Federal hospital, would be permitted if such sharing is in the national interest.

--Reimbursement would be made on the basis of full cost for each separate service; all money would remain within VA, available for subsequent use.

--No services to veterans would be compromised.

Budgetary restrictions

Several sharing opportunities were unsuccessful because of VA's inability to budget for the care of another agency's beneficiaries. Consequently, equipment which could have been shared was not shared because the needed staffing was not in the budget.

For example, the Tampa VA Hospital's (see app. IV, case study 16) proposed sharing agreement to give MacDill Air Force Hospital radiological services was unsuccessful. Tampa VA sent a proposed formal sharing agreement to VA's Central Office for review and approval. Tampa VA explained that it could provide the services MacDill needed at an annual cost of $120,000 to be paid by Air Force. Tampa VA officials stated that this amount would be adequate to recruit two radiologists and a clerk-typist to handle the increased workload. No difficulty was expected in recruiting these radiologists.

VA's Central Office denied the request for several reasons, including the fact that VA had no budgetary authority to enter into a formal sharing agreement in which personnel would be recruited to serve nonveterans' needs. Consequently, Air Force expected to purchase these services from civilian providers at an estimated cost of $240,000, twice the amount VA would have charged.

This same obstacle was present in several other case studies. (See app. IV, case studies 4, 7, and 14.)

On another issue related to budgetary obstacles, DOD has certain alternative means of treating its own beneficiaries which favorably affect an individual military facility's health care budget but ultimately negatively affect any possible opportunities to share Federal medical resources. These alternative means involve using CHAMPUS and transferring patients to other DOD facilities using the domestic aeromedical evacuation system.1/

The alternative of using CHAMPUS creates a lack of incentive for local military hospital managers to use nearby Federal facilities. Under CHAMPUS, dependents of military personnel, military retirees and their dependents, and dependents of deceased military members may receive medical care in a civilian medical facility if the services needed are not available in their designated military medical system facility.

Generally, for inpatient treatment these patients must obtain a certificate stating that needed care is not available in any local military facility within a 40-mile radius. A similar certificate is not required for outpatient care. However, CHAMPUS is funded under a separate DOD appropriation from that financing the operation of the facility issuing the nonavailability certificate. Consequently, the facility issuing the certificate has no incentive to seek care for CHAMPUS patients in a nearby Federal facility because it is not held accountable for the funds needed to pay CHAMPUS providers. On the other hand, if beneficiaries were referred to a VA hospital, for example, there might be a charge which would come out of the local military hospital's budget.

1/Under this sytem, DOD airlifts patients under medical supervision in specially equipped aircraft to, between, and from its medical treatment facilities.

For example, during 1976 about $25,000 of nuclear medicine diagnostic procedures and $6,500 for electronencephalograms were procured under CHAMPUS when Seattle VA, Seattle PHS, and Madigan Army Medical Center could have provided such services. (See app. IV, case study 3.) In addition, some VA facilities were providing care to CHAMPUS beneficiaries, while in other cases DOD officials believed VA could not treat such beneficiaries. (See app. IV, case studies 1, 8, 14, and 20.)

A similar lack of incentive exists in some instances when DOD hospitals use the domestic aeromedical evacuation system. Air Force transports military beneficiaries from one military medical facility to another, and military departments using the service are not charged. Flights can be routed to pick up possibly just one patient at no expense to the requesting hospital. Therefore, DOD hospital officials might tend to rely upon this alternative rather than using nearby Federal facilities.

An unnecessary use of the aeromedical evacuation system similar to that identified in an earlier GAO report ("Questionable Use of the Domestic Aeromedical Evacuation System," MWD-75-45, Apr. 21, 1975) involved patients air evacuated by Homestead Air Force Hospital. During 1976 Homestead air evacuated 51 neurology inpatients to other DOD hospitals. During this period Miami VA could have provided the needed services. Eight other patients were air evacuated to military hospitals in Georgia, Mississippi, and Texas for nuclear medicine scans. Miami VA could have provided this service also. (See app. IV, case study 17.) A similar example involved Cutler Army Hospital and the West Roxbury and Bedford VA Hospitals in Massachusetts. (See app. IV, case study 20.)

Time-consuming review of proposed sharing agreements

VA Central Office procedures for reviewing and approving proposed formal sharing agreements submitted by local VA hospital officials are unnecessarily complex and time-consuming. VA hospital officials told us that the time taken by VA's Central Office to review these proposals inhibits interagency sharing.

VA headquarters officials told us that the Central Office approval process can take more than 60 days if difficulties are encountered. Sometimes agreements are returned for resubmission because of technicalities. For example, at the San Diego VA Hospital, a proposal was returned because the wrong contracting authority had been cited. (See app. IV, case study 9.) In Seattle a proposed agreement took almost 10 months to obtain final approval. Also a Seattle VA physician told us that he was reluctant to share a newly developed highly specialized service because of administrative complexities in formulating and gaining approval of sharing agreements.

According to VA hospital officials, sharing would be facilitated by granting hospitals approval authority. One hospital director believed field officials should be authorized to approve contracts, agreements, or arrangements for sharing or exchanging medical resources. This authority would be subject to Central Office review and veto if the Central Office considered the agreement to not be in VA's or the Government's best interests. The local authority would, however, get things moving between participants without having to wait long periods for Central Office review.

Several DOD officials also mentioned VA's review procedures as constituting an obstacle to sharing. Officials at one Air Force hospital, for example, stated that VA officials take too long making up their minds about any type of agreement. They believed VA's procedures should be changed to allow local VA hospitals to negotiate and approve sharing arrangements.

Central Office officials, on the other hand, apparently believe review and approval should remain centralized. They told us the review period is supposed to take only 21 working days (about a month), but conceded that it could be longer if any of the several review control points--Supply Service, Professional Services, or General Counsel--had problems with the proposal. In 1974 authority was delegated to VA medical district directors to approve renewal sharing agreements where no changes had been made to the services being shared and costs had not increased by more than 10 percent.

A document used by VA's Office of Regionalization and Sharing in 1976 to brief VA officials on the VA sharing program contained the following excerpt which helps explain why Central Office reviews proposed sharing agreements:

> "A recommendation was made by a Medical District Director to decentralize the entire sharing program to the field. We do not believe the time has come to do this. We have less than 50 percent of our hospitals participating in the program. To those still uninitiated in 'sharing,' the program and what is intended is new territory. We do know from experience that even those VAH's [VA hospitals] that have

participated are prone to 'get off base' and require our assistance to stay within legal bounds."

INCONSISTENT AND UNEQUAL REIMBURSEMENT METHODS

A major obstacle to sharing involves reimbursement. Simply stated, no standard reimbursement mechanism exists between agencies, no clear policy is evident for allocating reimbursements back to providing hospitals, and reimbursement rates differ between agencies. Without adequate reimbursement hospital officials have no incentive for sharing and are reluctant to share.

Lack of standard reimbursement mechanism

VA uses two authorities--38 U.S.C. 5053 and the Economy Act, 31 U.S.C. 686--to share its medical resources with other Federal agencies.

Under 38 U.S.C. 5053, VA is required to obtain full reimbursement for any services provided and pay full costs for any services received. Full reimbursement means that VA must charge actual cost, including supplies used, and normal depreciation and amortization of equipment. Also VA may share only specialized medical resources at a level which will not reduce medical services to veterans. A formal sharing agreement is required, and services may be shared with Government, community, or private hospitals or clinics.

The Economy Act requires reimbursement based on actual cost. This reimbursement requirement has been satisfied by VA and other Federal agencies which use this authority by establishing, on an annual basis, daily inpatient and outpatient interagency rates, regardless of the service provided, based on total annual operating costs and the total annual inpatient and outpatient workloads. An interagency agreement, rather than a formal sharing agreement, is required under this statute.

Although both these authorities permit interagency sharing, the different reimbursement mechanisms restrict an active, continuing interchange of services. VA officials told us, for example, that from a budgetary standpoint there is a big incentive to provide services under the formal sharing authority (38 U.S.C. 5053) rather than under an interagency sharing agreement under the Economy Act.

Essentially, to furnish a "carrot" encouraging sharing, services provided under formal sharing agreement authority could result in double payment to the local hospital since (1) the patient is counted in the workload statistics used to request funds from the Congress with subsequent allocations to the hospital and (2) VA allocates total reimbursement for services provided under sharing agreements back to the providing hospital. On the other hand, services performed under interagency agreements are reimbursed to VA's Central Office on the basis of the daily inpatient and outpatient rates, regardless of actual cost of the specific services provided. However, the reimbursement is not allocated back to the individual hospital to help offset expenses incurred.

We attempted to followup at VA's Central Office about why reimbursements were being allocated to hospitals under formal sharing agreements, but not under interagency arrangements. Central Office Budget Staff officials could not give us any administrative regulation or directive or cite legislation which required reimbursements from interagency agreements not to be reallocated to the providing hospital. The Director, Budget Staff, believes it is incorrect to consider other agencies' reimbursements to VA hospitals as not being allocated back to the local hospitals. The Director told us that the total reimbursements received in the Central Office-controlled Treasury account are used to offset the budgetary requests VA makes to the Congress for medical care. Consequently, the total reimbursements from all sources--estimated for budget purposes in fiscal year 1977 to be $33 million--are redistributed to all VA hospitals. However, the VA budget system does not provide the means to determine how much reimbursement goes to each individual hospital. A hospital not sharing any services could receive just as much in reimbursement allocations as one which shared extensively.

As a further followup, in our May 1977 letter to the Administrator of Veterans Affairs concerning reimbursement and other sharing problems between the Tucson VA Hospital and Davis-Monthan Air Force Hospital, we inquired about VA's reimbursement policies. For example, we asked what VA's current policy was regarding allocating reimbursements from other agencies for medical services received from VA hospitals back to the providing hospital. VA's formal reply was similar to that stated above:

> "Reimbursements for medical services rendered other Federal agencies for which payment is based on the inter-departmental rates published in the Federal Register is not returned to the hospital when earned, but is allocated to each facility in the initial recurring target allowance. These funds

> are not identified separately, but the total funding allocations covers the inpatient and outpatient workloads assigned, including reimburseable workloads."

Because of VA's policy, VA hospital directors usually insist on using a formal (38 U.S.C. 5053) rather than an interagency (31 U.S.C. 686) sharing agreement. Under 38 U.S.C. 5053, which VA has used primarily for sharing with the private sector, hospitals are reimbursed. Under the Economy Act, however, reimbursements are not returned.

For example, at the Lexington, Kentucky, VA Hospital, a change in authority from a formal to an interagency sharing agreement resulted in a situation where services may not continue to be provided to two other Federal agencies unless Lexington VA recovers its costs. (See app. IV, case study 19.) One of these sharing agreements accounted for about $78,000 of the $92,000 of services provided by VA to other Federal agencies under this authority in fiscal year 1976. In addition, numerous other VA hospital officials told us they had no incentive to share services with other Federal agencies unless they were adequately reimbursed at the local level.

DOD's situation is not nearly as complex as VA's because DOD facilities have no sharing authority similar to VA's and sharing is done using interagency rates only. However, the same disincentive--lack of reimbursement--still exists.

DOD officials told us that their regulations do not allow providing hospitals to be reimbursed to the extent necessary to provide an incentive to share. Army, for example, does not allow any direct local reimbursement. Navy allows a partial reimbursement of outpatient charges, and Air Force indirectly reimburses through the budget process. Also many DOD hospital officials told us they lacked an incentive to share because their facilities would not be reimbursed.

Failure to agree on reimbursement rates

In VA's dealings with other Federal agencies, full cost reimbursements are generally required before VA provides services to other Federal agencies' beneficiaries. On the other hand, DOD is willing to provide to or procure services from other Federal agencies (e.g., VA) only on the basis of interagency rates. Full cost and interagency rates are very rarely the same. As a consequence, sharing between these Federal agencies is limited because of their failure to arrive at mutually agreeable reimbursement rates.

This point is clearly demonstrated in several case studies (see app. IV, case studies 2, 7, 8, 9, 11, and 14) and through our discussions with DOD officials. For example, Madigan Army Medical Center was prevented from providing renal dialysis to Seattle VA patients because estimated costs were higher than allowable DOD outpatient interagency rates. (See app. IV, case study 2.) Officials of the Army Health Services Command and the Office of the Army Surgeon General told us that interagency rates apply for both purchasing and providing direct care and supplemental care to other Federal agencies.

Navy officials also indicated that direct care services exchanged with other Federal agencies would have to be made on the basis of interagency rates. Port Hueneme Naval Hospital officials said they did not know whether Navy could reimburse VA as it did community physicians and hospitals from its supplemental care funds for services beyond Port Hueneme's capabilities. Subsequently, they contacted a Navy Bureau of Medicine and Surgery official, who said he knew of no procedures allowing the Navy to pay from supplemental funds.

Nevertheless, in a followup with the Bureau, the Deputy Comptroller told us that the Navy may consider actual (full) cost-sharing agreements with VA, but for supplemental care only. He said that the Economy Act is Navy's authority for interagency sharing, but Navy would probably be willing to enter into formal VA sharing agreements under 38 U.S.C. 5053 at full cost. No specific authority permits Navy to pay full costs, but there is no direct prohibition either. Therefore, Navy would consider a sharing agreement since it would be unfair to expect another agency (e.g., VA) to perform an expensive outpatient procedure for the Navy at a rate substantially lower than VA's full cost.

However, a formal sharing agreement would be considered only for supplemental care. In this case, the patient would not be disengaged from the Navy hospital and would continue to remain the Navy's responsibility. The hospital obtaining supplemental care would be responsible for reimbursement at rates prescribed by the providing facility. For all other types of direct patient referrals--inpatient or outpatient--the Bureau would reimburse the other Federal agencies at interagency rates.

Air Force headquarters officials stated that VA may be paid interagency rates for both direct and supplemental patient care, but actual practice differs in approaches to supplemental care. For example, patients from both the Davis-Monthan and

Kirtland Air Force Hospitals have received supplemental care from VA hospitals, but the different rates paid by these hospitals have caused problems. When Davis-Monthan was instructed to use interagency rates, a formal sharing agreement with VA was never finalized, while Kirtland has continuously paid full costs under a formal sharing agreement for supplemental services rendered by VA. (See app. IV, case studies 8 and 12.)

CHAPTER 3

CONCLUSIONS, RECOMMENDATIONS, AND AGENCY COMMENTS

CONCLUSIONS

The Federal Government has a unique opportunity to take the lead in medical resource sharing. To take full advantage of this opportunity will, however, require action by the Congress and a concerted effort by the involved agencies to eliminate obstacles to sharing and establish a Federal health care delivery system which would more efficiently use the systems administered by DOD, VA, and PHS.

Legislative and administrative obstacles to sharing could be eliminated without adversely affecting the level or quality of care given to each agency's primary beneficiaries. Eliminating the obstacles and implementing a structured Federal interagency sharing program would benefit both the Federal Government and the beneficiaries.

Increased sharing would benefit the Federal Government by providing opportunities for:

--Eliminating or consolidating underused or duplicative facilities, equipment, and staff.

--Reducing the reliance on health delivery programs such as CHAMPUS and CHAMPVA, which provide the care not available from DOD, VA, or PHS.

--Increasing staff proficiency and improving patient care by consolidating workloads and resources.

Beneficiaries might be able to be treated in Federal facilities closer to their residences. Also they might save money because CHAMPUS and CHAMPVA require individuals to pay specified portions of the cost of care.

The Economy Act and VA and PHS sharing laws are subject to interpretation and/or permit only certain types of resources to be shared. Consequently, it is difficult for agencies to use such legislation to increase interagency sharing because, frequently, Federal officials do not know what the specific groundrules are for such sharing. Therefore, little substantive and uniform guidance has been provided to local Federal hospital officials on interagency sharing problems and questions.

Several DOD, VA, and PHS officials have, over the years, pursued sharing arrangements. More recently, increased emphasis has been placed on the issue of sharing, particularly through the establishment of the interagency Federal Health Resources Sharing Committee. However, little additional sharing has yet actually taken place. If the amount of individual effort toward sharing in several cases we identified has failed to produce active sharing agreements, little chance exists for interagency sharing where Federal medical officials are not interested in sharing or do not know how to deal with other agencies' officials. Also, unless obstacles to sharing are eliminated, further efforts initiated by individual Federal officials or the Committee will continue to be impeded.

Agency regulations on interagency sharing are often vague and difficult to interpret. Such regulations make it very difficult for local Federal hospital and clinics to share because most regulations imply or agency policy dictates that there are not excess capabilities in any treatment areas and that services should be provided only in emergencies or when previous allocations of resources have been made. Also one agency's regulations are often difficult to mesh with another agency's regulations, and consequently few sharing agreements can be executed.

The lack of an effective and uniform reimbursement mechanism is the major obstacle at the individual Federal hospital and clinic level to increased interagency sharing. Any corrective action must incorporate an incentive to share. In this regard we believe a uniform provision to reallocate any reimbursement received back to the providing hospital is essential. Furthermore, we believe that any reimbursement mechanism should be flexible enough to encourage and permit negotiations between local Federal hospital officials to determine acceptable rates of reimbursement for services shared. Negotiated reimbursements could be based on all costs funded from current appropriations, incremental costs (costs in excess of fixed costs for an additional item of service), or some other cost which is mutually agreed upon. In any case, the reimbursements would be agreeable to both parties, excess Federal capability would be used, and sharing would take place.

Legislation is needed to require interagency sharing when appropriate and to encourage the establishment of Government-wide implementing procedures. Such legislation should encourage individual initiative without affecting any Federal agency's organizational or command structures. It should also give increased management options to local Federal medical officials to make the best use of our Nation's medical resources.

In view of the increasing concern in the Nation regarding the spiralling costs of health care, enacting legislation which establishes a firm Federal policy to promote Federal interagency sharing and removes restrictions on the types of services which can be shared would be both beneficial and timely. Enacting such legislation would also complement the national health priorities established by the National Health Planning and Resources Development Act of 1974 and provide the impetus and direction needed by Federal agencies to make interagency sharing more a rule than an exception.

RECOMMENDATIONS TO DOD, HEW, AND VA

We recommend that the Secretaries of Defense and Health, Education, and Welfare and the Administrator of Veterans Affairs:

--Jointly direct the Federal Health Resources Sharing Committee to expeditiously seek solutions to the administrative obstacles within each agency which impede sharing.

--Individually report annually to the appropriations committees of the Congress on the progress being made in implementing an effective sharing program.

RECOMMENDATIONS TO OMB

We recommend that the Director, OMB, establish a management group within the existing OMB organizational structure to work with DOD, HEW, and VA to coordinate the development of an effective interagency sharing program. Such a group should also work with Federal Health Resources Sharing Committee, and with OMB officials responsible for reviewing budget requests for Federal health care delivery activities to foster interagency sharing.

RECOMMENDATIONS TO THE CONGRESS

We recommend that the Congress enact legislation which would:

--Establish a policy that directs interagency sharing of Federal medical resources when appropriate.

--Authorize each Federal health provider to accept all categories of direct care beneficiaries on a referral basis when it would be advantageous to the Federal Government and care of primary beneficiaries would not be adversely affected.

--Eliminate all restrictions on the types of medical services which can be shared between Federal facilities.

--Authorize field hospital managers to approve agreements between Federal facilities, subject to headquarters veto only if judged not in the best interests of the Government.

--Permit agencies to expand services to treat beneficiaries of another Federal agency when such services would benefit the patient and the Government.

--Establish a policy requiring Federal facilities to use, if practical, nearby Federal direct health care resources before referring patients for care under programs such as CHAMPUS and CHAMPVA or to distant facilities within their own health care systems.

--Authorize the establishment of a reimbursement mechanism based on negotiated costs with a provision to reimburse the providing hospital with any revenues received to offset any expenses incurred. (This mechanism would allow Federal hospital officials to agree upon equitable and consistent fees on a medical service-by-service, hospital-by-hospital basis.)

--Assign to OMB the responsibility to (1) coordinate the implementation of an effective interagency Federal medical resources sharing program and (2) report annually to the Congress concerning the progress being made toward increased sharing of these resources.

ing

ratheluded in this report as appendix V is proposed legislation ..ich we believe would provide the legislative mandate necessary to implement an effective Federal medical resources sharing program.

EVALUATION OF AGENCY COMMENTS

The Departments of Defense and Health, Education, and Welfare generally agreed with the conclusions and recommendations in a draft of our report, except those relating to reimbursements for services shared between Federal hospitals.

(See apps. VI and VII.) VA (see app. VIII) did not agree with the management or funding concepts advocated in our draft report. Further, VA believed that our recommendations were not in accordance with "accepted and recognized Federal agency management principles and could be inadequate as a matter of law."

OMB (see app. IX) said that it was concerned about many of the problems discussed in our draft report. However, it was unwilling to take a position on the changes recommended for congressional action without additional detailed analyses and the determination of the potential impact of the recommended legislative changes. OMB disagreed with our recommendation that it establish a group to work with Federal agencies to coordinate the development of an effective interagency sharing program.

Reimbursements for shared services

Our draft report proposed that incremental costs become the legal basis for reimbursement for medical services exchanged among Federal agencies. This proposal was based on the fact that full cost reimbursements are not necessary. Full costs do not represent the "out-of-pocket costs" of providing services since costs such as salaries and utilities would be incurred whether or not services were provided to other agencies' beneficiaries. Also, the use of full costs would not provide adequate incentives for interagency sharing if lower rates were available in non-Federal hospitals. Therefore, incremental costs--those costs incurred for the provision of an additional item of service--appeared to be the logical choice as a basis of reimbursement for interagency sharing.

DOD, HEW, and VA all disagreed with the proposed recommendation. DOD and VA stated that reimbursements between agencies for shared services should be based on actual costs. DOD said that, when its uniform accounting system for military hospitals is fully implemented, it will be capable of identifying costs for specific medical services to the de that separate fees can be set for these services. DOD also said that reimbursement rates should be established centrally rather than by hospital. VA said that interagency reimbursements should be based on actual costs which represent an average uniform rate. It said that its billings should not be based on two rates--one for Federal beneficiaries and another for non-Federal institutions. HEW believed reimbursement between agencies should be made on a cost of service basis but recognized that it might be desirable to share resources by means of even exchange. Regardless of the cost basis adopted, HEW suggested that the specific reimbursement mechanism should be left to the agencies to develop within broad general agreements negotiated by, for example, the Federal Health Resources Sharing Committee.

In view of the agencies' comments on this proposed recommendation and because the agencies' accounting systems do not now identify elements of cost for individual medical services, we are now recommending that reimbursements for shared services be negotiated and mutually agreed to by local Federal hospital administrators. As the agencies' willingness to share increases and their cost accounting systems become more sophisticated, it seems reasonable to us to expect that incremental costs could eventually become the standard basis of reimbursements for medical services shared between Federal agencies.

DOD concurred in our recommendation that reimbursements received by individual hospitals for shared services be returned to providing hospitals as an incentive to promote interagency sharing of Federal medical resources. HEW did not agree, stating that hospitals providing services to other agencies' beneficiaries should be funded on the basis of total workload regardless of origin, with reimbursements paid centrally and credited to the agencies' total budgets. According to HEW, to do otherwise would tend to unbalance the distribution of an agency's resources and create an undesirable competition for patients and the financial resources they represent.

VA emphasized that it believes it has an effective and consistent mechanism under which it seeks reimbursement for services rendered to other Federal facilities in two ways--either by an interagency agreement (under 31 U.S.C. 686) or a sharing agreement (under 38 U.S.C. 5053). VA stated that in both instances actual costs are realized in accordance with present legislation. Our review showed that the ways in which cost reimbursements under these two statutes are recovered in actual practice differ substantially. In practice, the different reimbursement mechanisms favor the sharing of VA's resources with non-Federal health providers rather than Federal agencies.

As discussed earlier, reimbursement rates under interagency agreements are derived from establishing average daily inpatient and outpatient rates based on total annual operating costs and total annual inpatient and outpatient workloads. Therefore, the rates do not reflect the full actual cost of each medical service provided. In effect, VA receives as reimbursement only an "average actual cost" which, in the case of highly specialized procedures, may be substantially less than a VA hospital's full cost of providing the services. In addition, reimbursements generated as a result of interagency agreements are not reallocated back to the individual VA hospital which provided services to other agencies' beneficiaries. Therefore, from the perspective of the individual VA hospital, the only readily identifiable benefit to sharing under interagency agreements is that the workload generated through sharing is counted as part of its overall workload upon which its annual budget allowances are calculated.

However, if the target budget allowance for a VA facility is, for any reason, reduced, interagency sharing--ongoing or planned--must be curtailed since the facility's first obligation is to serve eligible veterans. Under these circumstances if any sharing occurs, the facility must absorb the costs of such efforts as part of its reduced budget allocation.

On the other hand, the reimbursement mechanism used by VA to provide services under sharing agreements is substantially different from that under interagency agreements. Under sharing agreements, reimbursements are received by the VA Central Office for the full cost of each specific service provided. The revenues collected are subsequently reallocated, on a quarterly basis, to the VA hospital which provided the service. In addition, the workload generated because of sharing is also included in the individual VA hospital's workload statistics used as the basis to request appropriations for operating funds from the Congress. In effect, a VA hospital which provides services under sharing agreements could receive a double payment for the services it provides to others.

The differences in VA's reimbursement mechanism under the two sharing authorities have, in our opinion, historically contributed to the lack of significant sharing between VA and other Federal agencies. Nearly all of the services VA provides for other Federal hospitals have been provided under interagency agreements because either (1) VA Central Office officials believe these are the appropriate agreements for its hospitals to use in dealing with other agencies or (2) the other agencies are willing to reimburse VA only based on rates established under interagency agreements--that is, those based on the average actual costs of services VA provides to their beneficiaries. In contrast a substantial volume of services (about $16 million in fiscal year 1977) is shared between VA and non-Federal health providers under its sharing agreement authority but very little (about $26,000 in fiscal year 1977) is shared between VA and other Federal agencies, although this authority specifically authorizes VA to share specialized services with other Federal hospitals. Because the reimbursement mechanism under interagency agreements provides local VA hospitals little incentive to share while the mechanism under sharing agreements provides them much greater incentives, it is easy to understand why VA's sharing with other Federal agencies has been limited.

Other Comments

DOD and HEW

Both DOD and HEW expressed their support for the concept of increased interagency sharing of Federal medical resources and cited several actions that have already been taken toward this objective. The departments agreed in principle with our recommendations that:

- --Federal agencies be permitted to expand services to treat beneficiaries of another Federal agency when such services would benefit the patient and Government,
- --local hospital managers be permitted to negotiate sharing agreements, and
- --a policy be established requiring Federal facilities to use nearby Federal resources before selecting other more costly or distant sources of treatment.

DOD agreed with the last of the above recommendations but stated that it did not want its patients to travel beyond 40 miles from their place of residence to obtain such care. Neither DOD nor HEW wanted to be required to first use other Federal facilities. DOD expressed the view that the policy we recommend should be flexible enough to allow for exceptions on a case-by-case basis when such exceptions would benefit other activities, such as military medical teaching programs. HEW expressed concern that, if services could be obtained at a lower cost from private sources, there should be no requirement to use a more costly Federal source of care.

We agree that a policy requiring interagency sharing should not be so rigid as to allow for no exceptions. However, we do not agree that the imposition by DOD of a strict rule regarding the distance patients live from a Federal medical treatment facility should be included as a blanket exception to the policy we are recommending. In this regard, DOD now routinely transports many patients great distances on its domestic aeromedical evacuation system to receive care. We believe that, unless a transfer to a distant Federal medical facility can be fully justified based on the specific medical care needs of the patient, lower costs in the private sector, or in rare instances, the needs of a medical teaching program, sharing with nearby Federal facilities should be required.

VA

VA recognized the need for development of a coordinated approach to health care planning among Federal agencies and pointed out the recent contributions that its Department of Medicine and Surgery has made toward establishing the Federal Health Resources Sharing Committee. It stated its belief that administrative remedies would be more appropriate than legislative remedies to overcome the obstacles to sharing we identified.

VA also said it would be remiss if it did not address certain policy issues that would affect the implementation of our recommendations. In this regard, VA stated that the American people, acting through the President and the Congress, have expressed a special concern for its citizens who have devoted parts of their lives to the Nation's defense. Medical care to these veterans has been the mission of VA since 1930, and the creation in 1946 of VA's Department of Medicine and Surgery made VA solely responsible for the treatment of veterans.

VA believed that our recommedations seem to favor an amalgamation of resources for the benefit of all beneficiaries in the Federal sector. It stated that our recommendations must be considered in accordance with VA's primary mission of caring for veterans. Further, according to VA, since (1) there is no agreement on VA's role in any forthcoming national health insurance program and (2) various options are still being considered by the President concerning the provision of the Nation's health care needs, it would be unwise to enact legislation implementing our recommendations.

We do not agree with VA's statementsrregarding the policy implications of our recommendations. Throughout our review we have recognized the concerns of the involved agencies regarding their primary mission and have developed our recommendations with these concerns in mind. The implementation of our recommendations would not, as VA has indicated, necessarily result in a "amalgamation" of Federal health resources. Rather their implementation would enhance the abilities of each agency's hospital directors to seek and obtain alternative sources of care for their beneficiaries, while taking advantage of opportunities to control the Government's increasing health care costs.

Regarding VA's concerns about the future direction of Federal health care, we believe that the Government, through the initiation of a congressionally directed and effectively implemented interagency sharing program, has a unique opportunity to take the lead in health care planning and coordination activities. Such activities will undoubtedly become important factors in future programs developed to control the Nation's health care costs.

OMB

As previously discussed, OMB did not agree that it should establish a group to work with the involved agencies to coordinate the development of an effective sharing program. OMB said it would rely on its budget examiners and other staff already working with the agencies affected by our recommendations in considering further actions to address sharing problems.

We believe that the issue of sharing medical resources among Federal agencies has progressed to the point where OMB should assume a stronger role than it has in the past. The divergent views expressed by DOD, VA, and HEW concerning our report indicate a lack of an overall executive branch policy on this issue. We believe that OMB's traditional reliance on its budget examiners to recommend the proper course of action for an interagency sharing program will be inadequate because its organization of budget examiners is structured along individual agency lines. HEW, in its comments, suggested that centralization of sharing coordination within OMB should be a managerial rather than a budget process so that it might be prospective, affirmative, and guiding in its approach. We agree and believe that the establishment of a managerial group within the existing OMB organizational structure to work with the recently established Federal Health Resources Sharing Committee, the involved agencies, and OMB budget examiners is essential to the development of an effective Federal sharing program.

- - - - -

Over the years, Federal agencies have become increasingly concerned with their abilities to provide quality health care to their primary beneficiaries. However, little attention has been given to taking advantage of the opportunities to improve patient care and reduce Federal health

care costs through interagency sharing of medical resources. In fact, because of the emphasis on individual agencies' capbilities, several obstacles have evolved which now make sharing--even when it is tried--much more difficult. We endorse the establishment of the Federal Health Resources Sharing Committee as a vehicle to discuss agencies' mutual interests. However, we believe the enactment of legislation to provide the impetus for an effective Federal medical resources sharing program and a concerted effort by the involved agencies to make sharing a routine occurence are essential if the Government's direct health care providers are to realize their full potential.

CHAPTER 4

SCOPE OF REVIEW

We made our review at the headquarters offices and selected health care facilities of DOD, VA, and HEW, the three major Federal direct health care providers. Our general objective was to evaluate and substantiate the feasibility and desirability of increased interagency sharing. We concentrated on identifying obstacles to sharing. In identifying legislative and administrative obstacles, we concurrently identified potential opportunities for interagency sharing.

In identifying obstacles we analyzed existing legislation and regulations pertaining to interagency sharing. We obtained interpretations of the legislation and regulations from officials of DOD's Office of Assistant Secretary of Defense (Health Affairs); Offices of the Surgeons General of the Army, Navy, and Air Force; the DOD Health Council; various VA Central Office officials, including the Administrator of Veterans Affairs; and PHS' Bureau of Medical Services. Our work with these officials was conducted at their headquarters offices in the Washington, D.C., area. We also visited Army's Health Services Command in San Antonio.

To identify obstacles at the field level, we discussed with Federal hospital managers their interpretations of legislation and regulations affecting their dealings with other agencies. We developed information at individual Federal hospitals and clinics for subsequent use as case studies to demonstrate opportunities for sharing and obstacles to sharing. We met with VA medical district directors and their staffs, DOD regionalization coordinators, and civilian health planning officials to solicit their views on sharing Federal medical resources. Also we used data developed for us by CHAMPUS headquarters in Denver to determine whether Federal hospitals could have absorbed some of the CHAMPUS workload being provided by civilian facilities in selected geographic areas.

HOSPITALS AND CLINICS REVIEWED

The following Federal hospitals and clinics were reviewed:

Seattle-Tacoma, Washington, area

Madigan Army Medical Center
Naval Regional Medical Center, Bremerton
Naval Hospital, Whidbey Island
Veterans Administration Hospital, Seattle
Veterans Administration Hospital, American Lake
U.S. Public Health Service Hospital, Seattle

San Francisco, California, area

Letterman Army Medical Center
Naval Regional Medical Center, Oakland
David Grant Medical Center (Travis Air Force Base)
Veterans Administration Hospital, San Francisco
Veterans Administration Hospital, Martinez
U.S. Public Health Service Hospital, San Francisco

Los Angeles, California, area

Naval Regional Medical Center, Long Beach
Naval Hospital, Port Hueneme
Air Force Regional Hospital, March Air Force Base
Veterans Administration Hospital, Long Beach
Veterans Administration Hospital, Loma Linda

San Diego, California, area

Naval Regional Medical Center, San Diego
Veterans Administration Hospital, San Diego

Tucson, Arizona, area

Air Force Hospital, Davis-Monthan Air Force Base
Veterans Administration Hospital, Tucson
Indian Health Service, Tucson

Albuquerque, New Mexico, area

Air Force Hospital, Kirtland Air Force Base
Veterans Administration Hospital, Albuquerque

Colorado-Wyoming area

Fitzsimons Army Medical Center, Denver, Colorado
Air Force Hospitals F.E. Warren Air Force Base, Cheyenne, Wyoming
Air Force Clinic, Lowry Air Force Base, Denver, Colorado
Veterans Administration Hospital, Denver, Colorado
Veterans Administration Hospital, Cheyenne, Wyoming

Temple, Texas, area

Darnall Army Hospital (Ft. Hood)
Veterans Administration Hospital, Temple

Tampa, Florida, area

Air Force Regional Hospital, MacDill Air Force Base
Veterans Administration Hospital, Tampa
U.S. Public Health Service Clinic, Tampa

Miami-Key West, Florida, area

Naval Hospital, Key West
Air Force Hospital, Homestead Air Force Base
Veterans Administration Hospital, Miami
U.S. Public Health Service Clinic, Miami

Lexington, Kentucky, area

Veterans Administration Hospital, Lexington
Federal Correctional Institution, Lexington
National Institute of Drug Abuse, Addiction Research Center, Lexington

New England area

Cutler Army Hospital (Ft. Devens), Massachusetts
Naval Regional Medical Center, Newport, Rhode Island
Air Force Clinic, Hanscom Air Force Base, Massachusetts
Veterans Administration Hospital, Boston, Massachusetts
Veterans Administration Hospital, West Roxbury, Massachusetts
Veterans Administration Hospital, Brockton, Massachusetts
Veterans Administration Hospital, Bedford, Massachusetts
Veterans Administration Hospital, Providence, Rhode Island
U.S. Public Health Service Hospital, Boston, Massachusetts

MAJORITY MEMBERS
GEORGE H. MAHON, TEX.,
CHAIRMAN
JAMIE L. WHITTEN, MISS.
ROBERT L. F. SIKES, FLA.
OTTO E. PASSMAN, LA.
JOE L. EVINS, TENN.
EDWARD P. BOLAND, MASS.
WILLIAM H. NATCHER, KY.
DANIEL J. FLOOD, PA.
TOM STEED, OKLA.
GEORGE E. SHIPLEY, ILL.
JOHN M. SLACK, W. VA.
JOHN J. FLYNT, JR., GA.
NEAL SMITH, IOWA
ROBERT N. GIAIMO, CONN.
JOSEPH P. ADDABBO, N.Y.
JOHN J. MC FALL, CALIF.
EDWARD J. PATTEN, N.J.
CLARENCE D. LONG, MD.
SIDNEY R. YATES, ILL.
FRANK E. EVANS, COLO.
DAVID R. OBEY, WIS.
EDWARD R. ROYBAL, CALIF.
LOUIS STOKES, OHIO
J. EDWARD ROUSH, IND.
GUNN MC KAY, UTAH
TOM BEVILL, ALA.
BILL CHAPPELL, JR., FLA.
BILL D. BURLISON, MO.
BILL ALEXANDER, ARK.
EDWARD I. KOCH, N.Y.
YVONNE BRATHWAITE BURKE, CALIF.
JOHN P. MURTHA, PA.
BOB TRAXLER, MICH.
ROBERT DUNCAN, OREG.
JOSEPH D. EARLY, MASS.
MAX BAUCUS, MONT.
CHARLES WILSON, TEX.

Congress of the United States
House of Representatives
Committee on Appropriations
Washington, D.C. 20515

MINORITY MEMBERS
ELFORD A. CEDERBERG, MICH.
ROBERT H. MICHEL, ILL.
SILVIO O. CONTE, MASS.
GARNER E. SHRIVER, KANS.
JOSEPH M. MC DADE, PA.
MARK ANDREWS, N. DAK.
BURT L. TALCOTT, CALIF.
JACK EDWARDS, ALA.
ROBERT C. MC EWEN, N.Y.
JOHN T. MYERS, IND.
J. KENNETH ROBINSON, VA.
CLARENCE E. MILLER, OHIO
LAWRENCE COUGHLIN, PA.
C. W. BILL YOUNG, FLA.
JACK F. KEMP, N.Y.
WILLIAM L. ARMSTRONG, COLO.
RALPH S. REGULA, OHIO
CLAIR W. BURGENER, CALIF.

CLERK AND STAFF DIRECTOR
KEITH F. MAINLAND

TELEPHONE:
CAPITOL 4-3121
EXT. [illegible]
OR
[illegible]

January 10, 1977

Honorable Elmer B. Staats
Comptroller General of the United States
General Accounting Office
441 G Street, N.W.
Washington, D.C. 20548

Dear Mr. Staats:

As you know, the Committee recently requested that your Office conduct two studies to determine the potential for Federal agencies such as the Departments of Defense and Health, Education and Welfare, and the Veterans Administration to share expensive and highly specialized cardiac catheterization and computed tomography capability. It appears from discussions with your representatives that Federal sharing of these services could yield savings to the Government.

We understand that your Office's Human Resources Division is considering initiating a broader study to determine whether additional opportunities exist for agencies to share perhaps less specialized but possibly equally expensive Federal delivery capability and to identify the legislative, administrative and other obstacles that might currently exist to preclude the optimum use of Federal capability through sharing.

The Committee requests that emphasis be placed on such a study in view of the rapidly increasing costs involved in the delivery of health care. We are particularly interested that any opportunities available to share existing Federal health capability without adversely impacting on the quality of care being provided be explored carefully.

The Committee understands that such a review will be a complex and time-consuming undertaking and therefore is not requesting a report until January 1978. However, we would appreciate remaining apprised of the progress of the review so that information being developed can be discussed with the officials of the departments and agencies requesting appropriations for the provision of health services and for the construction of additional health facilities.

The Committee looks forward to receiving a report on the results of your review and particularly your recommendations for overcoming the obstacles to the full sharing of Federal health resources. The staff of the Committee remains available to discuss the details of this request. Thank you for your assistance in providing the Committee with assistance in this increasingly costly area of Federal activity.

Sincerely,

George Mahon

Chairman

PRIOR STUDIES INDICATE CONTINUOUS CONCERN OVER MANAGEMENT AND PROPER USE OF FEDERAL MEDICAL RESOURCES

Over the past 30 years, several reports and studies have discussed the proper type of management needed by DOD, VA, and PHS to more effectively operate their medical facilities. Several of these studies were conducted because of legislative requirements or because of congressional direction. These reports have addressed, on various occasions, management of one agency's own resources in a specified geographical area (regionalization), use of one agency's resources by another agency (sharing), and management of the separate health care delivery systems under one administration (unification). In addition, for the past several years we have issued several reports which demonstrate that Federal hospitals can better use medical resources.

HOOVER COMMISSION REPORTS

In 1947 and 1953 the Congress established Commissions on Organization of the Executive Branch of the Government to determine what changes were necessary to promote economy, efficiency, and improved service in, among other things, the delivery of health care by Federal agencies. These Commissions were commonly known, respectively, as the First and Second Hoover Commissions.

First Hoover Commission Report

The first Commission's March 1949 report to the Congress criticized:

--Medical construction programs going forward although Federal hospitals had unused capacity.

--The lack of planning by Federal agencies with little knowledge of, and no regard for, the needs of the Nation as a whole.

--The lack of a clear definition by the Congress of the rights and priorities to medical care of all the classes of beneficiaries. (The Commission believed that hospital care for Federal beneficiaries should be planned in relation to the hospital resources of the country as a whole, not merely through construction of Federal hospitals.)

Second Hoover Commission Report

The second Commission's February 1955 report to the Congress indicated that little fundamental improvement in Federal medical services had been made since the issuance of the first Commission report in March 1949.

The second Commission report pointed out similar examples of waste and lack of coordination identified by the first Commission. The Commission proposed specific remedial actions, including:

--Creating a Federal Advisory Council of Health where medical policies and activities could be reviewed to further coordination, eliminate duplication, and develop overall policies.

--Developing regional coordinated administration of military hospital services.

--More cross-servicing between the military hospitals and between VA and PHS hospitals.

The Commission recommended creating a Federal Advisory Council of Health because the responsibility of recommending overall Federal policies was not fixed in any executive branch unit. Consequently, because of this lack of overall policy, excessive duplication of programs, facilities, and personnel existed. Such excesses, in its opinion, not only impaired the economic and efficient operation of Federal health activities, but placed unreasonably heavy claims upon the Nation's total health economy.

The Commission thought that its recommendations could be put into lasting effect only if they became the explicit responsibility of a permanent council. The Commission concluded that the best place for such an organization was within the Executive Office of the President.

DOD STUDIES

The organizational structure of the military's health care delivery systems has been an issue since DOD was established in 1947.

Each study tried to determine how to obtain increased efficiency and economy from three distinct health care systems (Army, Navy, and Air Force) with each health care system controlled by a different surgeon general. Options presented in these studies ranged from no change to unification of the systems into one entity. Regionalization--

collectively organizing and managing a system of peacetime health care delivery in specified geographic areas in order to increase productivity and achieve economy without unnecessary duplication of resources--has emerged as a compromise between the two extremes.

Major studies and a brief discussion of the views expressed in each follow.

DOD Committee on Medical and Hospital Services of the Armed Forces (1949)

The Committee examined three alternative organizational structures: a unified medical service supporting all three military departments; a single manager plan, under which one service would be responsible for military medicine in support of all military departments; and separate but coordinated medical services for each military department.

The Committee rejected a single medical service in any form, noting

> "separation of the medical services from the departments they serve and sustain * * * would greatly reduce the efficiency and effectiveness of the medical services in rendering medical support to the various departments and agencies of the National Military Establishment."

They recommended coordination and policy guidance at the Secretary of Defense level.

Armed Forces Medical Advisory Committee (1949)

This Committee was a military-civilian group formed to to advise the Secretary of Defense on health and medical matters. In the first half of 1949, the Committee considered a Joint Chiefs of Staff recommendation that "the Secretary of Defense immediately institute studies and measures intended to produce, for the support of the three fighting services, a completely unified and amalgamated [single] medical service."

Military medical department summaries of that study indicate that the Committee had concluded that "the objectives of unification are highly desirable" but stated further that "so much of the medical department as is essential for medical support of each of the Armed Forces [should] remain as integral parts of these forces."

Coller Report (1958)

This report was prepared in response to President Dwight D. Eisenhower's request that Dr. Frederick Coller, a non-DOD physician, determine if it would be advantageous to designate one service as the single manager for military health services. Dr. Coller's report supported the continuation of three separate but coordinated medical departments.

Comprehensive Medical Services Program Review Report on Unification of Military Medical Departments (1966)

None of the Program Review Group believed that continuing the status quo was a satisfactory answer to the needed management of DOD medical resources. On the other hand, most members initially preferred to avoid the other extreme of complete unification.

However, the growing realization and appreciation of the complex and interlocking nature of each military department's medical service led the participants to conclude that unification to the greatest degree possible was the only viable and worthy alternative. As a result the report recommended establishing a Defense Medical Service and concurrently disestablishing the Offices of the Surgeons General of the three military medical departments.

Clifford/Nitze Report (1968)

This report was prepared because Secretary of Defense Clark Clifford had been asked by a Special Assistant to the President for his views on unification of the military health services. Deputy Secretary of Defense Paul Nitze stated that unification was not desirable or feasible.

Reasons cited were that many functions already were consolidated and a substantial and critical portion of each medical service was closely integrated with the force it supported. Consequently, as long as the services maintained their separate identities, unification was not realistic.

DOD-HEW Study ("Reducing the Needs for Military Medical Personnel in the Armed Forces") (1972)

This study recommended that:

--A peacetime health services system be regionalized on a triservice basis.

--Military health care facilities be partially staffed with civilian health professionals on a contractual basis.

"Military Health Care Study" (1975)

This study, undertaken at the direction of the President, was made to (1) assess the ability of the current military health care system to meet the future needs of the Armed Forces and (2) recommend ways to ensure quality medical care for all DOD beneficiaries which were consistent with the national health care initiatives and DOD's missions and objectives.

The study was conducted by representatives of DOD, HEW, and OMB. Of particular importance to DOD's management of resources were these recommendations:

--A central DOD coordinating entity for planning and allocating resources should be established to oversee health care delivery in the continental United States.

--Oversight of health care delivery should be assigned to regional authorities responsible for all health care delivery in their geographical areas.

As a result of the first recommendation, a DOD Health Council was established in December 1976 to coordinate DOD health care activities.

Report on the Feasibility of Sharing Medical Facilities (1976)

In this report the Assistant Secretary of Defense (Health Affairs) reported to the Chairman, Senate Appropriations Committee, as requested during the fiscal year 1977 DOD appropriations hearings, on the feasibility of sharing medical facilities. The Assistant Secretary stated that DOD solidly agreed with the idea of sharing and pointed out the extent to which it already existed. The report concluded that a significant amount of cooperation, coordination, and sharing currently existed between DOD, VA, and PHS. However, the Assistant Secretary cautioned that the achievable level of sharing was limited by the following factors:

--The health programs of each group are somewhat unique based on the beneficiary population served. This is particularly evident in program differences emphasizing short-term care versus long-term chronic care.

- --DOD must provide adequate staff and facilities to support wartime mobilization. This core of resources is most efficiently used during peacetime to care for additional beneficiaries on a space-available basis.
- --An appropriate balance between the Federal agencies must be achieved which will not result in care not being available when surges in demand occur.
- --Medical practice currently emphasizes ambulatory care, a service in short supply for all Federal agencies. Opportunities for sharing are limited by the few locations where more than one Federal facility is present and at least one has capacity it can share.

Comparative Health Facility Acquisition Methodology Study (1977)

In February 1976 the Subcommittee on Military Installations and Facilities, House Committee on Appropriations, became concerned with the increased cost of acquiring military health facilities. Testimony before the Subcommittee revealed that estimates for construction of newly designed facilities sometimes increased by over 100 percent from original preliminary estimates.

DOD was directed to undertake a study for the purpose of making recommendations that, if implemented, would hold down the costs of providing military health facilities, while providing an acceptable health care delivery capability.

The following recommendations from the study were among those considered to have the highest priority for implementation because of their potential impact:

- --Accelerate the implementation of a regional military health care system. All alternative resources which can provide health care more economically should be considered in assessing the need for and the planning of any new facility. This assessment should include shared services, cooperative efforts, and other program methods between military health care facilities and between the military and VA and/or civilian facilities.
- --DOD, VA, and HEW should establish a Coordinating Council for the planning/programing of health care facilities. The Council's mission would be to stimulate and implement the sharing of ideas and information; discuss problems common to all agencies; and

coordinate efforts to accelerate progress and avoid significant duplication of effort.

VA STUDIES

Since the mid-1960s, VA has been authorized to share its specialized services with non-VA medical facilities. One major report addresses issues involved in the VA regionalization and sharing programs.

"Health Care for American Veterans" (1977)

On June 3, 1977, the National Academy of Sciences' Committee on Health Care Resources in VA released this report. Overall the committee was particularly interested in learning why the scope of shared services, both between VA and non-VA hospitals and between VA hospitals, remained so small 10 years after the Congress had authorized sharing. It also wanted to explore the extent to which the parallel policies of sharing between VA and outside facilities and regionalization within VA were compatible.

The committee found that 92 percent of all the services bought and sold by VA under sharing contracts in fiscal year 1975 had been exchanged between VA and non-VA hospitals affiliated with the same medical school. The committee concluded that this situation had probably occurred because the physician specialist in charge of the shared services was on the staff of both hospitals and therefore could coordinate patient care, teaching, and research in both hospitals. In cases of specialized medical services, the committee found, in almost all cases, evidence of operation below minimal standards and under the present circumstances, no workable local mechanisms or incentives to foster sharing. Because sharing agreements are initiated and continued by individual VA hospital officials, the incentives to fostering sharing are important. Except for the situations involving affiliated hospitals, the committee found no incentives to share with non-VA hospitals.

The committee also found the interpretation of sections 5051 to 5053 of title 38 by the VA General Counsel to be too restrictive. These sections allow VA to share specialized medical resources with non-VA health care facilities. Moreover, the committee believed changes in incentives and VA budgetary procedures were necessary to realize the potential benefits of sharing between VA and non-VA facilities.

The committee could not arrive at a definite assessment of the VA regionalization program because VA was pilot testing a new system in 6 of the 28 medical districts. VA hoped this new system would reduce duplication of costly medical programs and promote sharing between VA hospitals in the same medical district. However, the committee cautioned that the emphasis of allocating medical resources among VA facilities had the potential for reinforcing the separation of VA facilities from local non-VA facilities. Therefore,

> "by not considering the availability of specialized and other medical services in the non-VA sector before allocating these resources to the network of VA hospitals, the VA * * * limited the alternatives from which to choose the best way to make specialized and other medical services available and easily accessible to its patients."

PHS

Neither HEW nor any outside parties have completed formal studies or reports on sharing PHS medical resources with other Federal agencies. However, during the past 15 years a series of congressional hearings has been conducted concerning the potential role of PHS hospitals. For example, the Webster Committee Report of June 19, 1965, recommended that:

--PHS continue to operate a system of general hospitals.

--PHS general hospitals be modernized and be supported at levels consistent with the several important functions they should perform.

--Additional training programs be developed in sciences and services basic to medicine and existing programs be strengthened and extended. Responsibility for these programs should be shared with universities and with other community health agencies.

GAO'S PRIOR STUDIES OF FEDERAL HOSPITAL SYSTEMS' OPERATIONS

Reports on DOD

We have issued three reports on DOD's use of medical resources in treating beneficiaries.

Our April 21, 1975, report entitled "Questionable Use of the Domestic Aeromedical Evacuation System" (MWD-75-45) to the Secretary of Defense discussed how the domestic segment of the worldwide patient airlift system operated and suggested improvements. On the basis of questionnaire responses and other information, we concluded that the need for the system as it currently operated was questionable. For example, responses showed that 80 percent of the referrals could have received care at or near their originating military facilities or at military facilities closer than those to which they had been transferred. Furthermore, about half the referrals could have been made by transportation means other than domestic aeromedical evacuation.

Our report to the Congress entitled "Policy Changes and More Realistic Planning Can Reduce Size of New San Diego Naval Hospital" (MWD-76-117, Apr. 7, 1976) examined the DOD criteria used to size new military hospitals. The criteria were deficient and their continued use would result in constructing hospitals with excess acute care beds.

Our report raised two policy questions for the consideration of the Congress.

1. Who were the new facilities being built for?

2. To what extent should DOD and other Federal hospitals be required to share excess acute care beds as an alternative to new construction?

The sharing question was raised because the San Diego VA Hospital and the Camp Pendleton Naval Hospital--both in the San Diego area--had 150 and 160 excess acute care beds, respectively. We suggested that sharing these facilities offered an attractive alternative to constructing new capacity at the San Diego Naval Hospital.

In July 1976 the Congress did give DOD the following policy guidance:

--A method of determining the number of acute care hospital bed requirements for active duty members and their dependents.

--Guidance on providing bed capacity for other eligible beneficiaries.

--Direction on the coordination needed between the Federal and civilian health care representatives.

Our report entitled "Congressional Policy Guidance Should Improve Military Hospital Planning" (HRD-77-5, Nov. 18, 1976) focused on the congressional guidance provided and DOD action needed to insure that future hospital planning was in accordance with this guidance.

Reports on VA

We have issued eight reports in the past few years which discussed primarily the use of VA's medical resources.

Our June 19, 1972, report to the Congress entitled "Low Use of Open-Heart-Surgery Centers at Veterans Administration Hospitals" (B-133044) discussed use of VA specialized medical services. As noted in several other reports discussed below, these services were underused in several locations. We recommended that the program be evaluated to redetermine the number and locations of open-heart-surgery centers needed.

Our April 11, 1973, report entitled "Better Use of Outpatient Services and Nursing-Care Bed Facilities Could Improve Health Care Delivery to Veterans" (B-167656) said VA could make better use of its outpatient services and the number of veterans referred to private dentists could be reduced if dental resources were better coordinated between neighboring VA stations.

In our November 13, 1973, report entitled "Need for Improvement in Certain Hospital Laboratory Service Activities" (B-133044) we discussed the need for improved program planning and management in certain areas. For example, although VA obtained most of its blood from volunteers, it could have obtained more by establishing a cooperative program with the military to obtain volunteer blood that exceeds the military's needs. Also the large number of electron microscopes acquired by VA had resulted in low overall use, and the future planned acquisition of additional units was questionable.

Our March 20, 1974, report to the Congress entitled "Complications Incurred Because of Delays in Transferring Patients to VA Spinal Cord Injury Treatment Centers" (B-133044) said spinal cord injury patients--particularly servicemen--were not being transferred to VA facilities as soon as medically feasible. Thus many incurred medical complications which slowed their rehabilitation, lengthened their hospitalization, and increased the cost of health care.

We recommended that:

--The Administrator of Veterans Affairs work with the military to develop a system to expedite the transfer of spinal cord injury patients to VA centers.

--The Secretary of Defense revise military procedures and regulations to permit transfer of spinal cord injury patients to VA centers as soon as medically feasible.

In our report entitled "Better Planning and Management Needed by the Veterans Administration to Improve Use of Specialized Medical Services" (B-133044, June 19, 1974) we reported to the Congress that VA hospitals had established and operated such specialized medical services as supervoltage therapy, kidney transplants, and hemodialysis, even though many were underused and duplicated existing facilities. VA, we said, could improve the management and operation of these programs. We recommended that VA establish, maintain, and periodically review criteria and guidelines; and provide necessary information to periodically evaluate the programs' effectiveness.

Reports on use of medical resources were issued to the Administrator of Veterans Affairs on September 17, 1975, and May 20, 1976. The first dealt with a need to share specialized medical services, specifically cardiac catheterization laboratories. The second was a followup of VA's laboratory operations to determine if an earlier report's recommendations ("Need for Improvements in Certain Hospital Laboratory Service Activities," B-133044, Nov. 13, 1973) had been effectively implemented.

The first report concluded that the establishment of a cardiac catheterization laboratory at the Sepulveda, California, VA Hospital had not been warranted because (1) patient demand for cardiac catheterization had not been determined and (2) based on available standards, the laboratory at the nearby Wadsworth, California, VA Hospital was underused even though patients had been transferred from the Sepulveda VA Hospital.

The second report concluded that VA's laboratory service fee-basis testing costs had been high and reducing these costs through regionalization efforts had been limited. This situation occurred because VA's Central Office had failed to actively control the progress of efforts to regionalize laboratory services or adequately evaluate and coordinate field activities.

Our February 28, 1977, report entitled "Many Cardiac Catheterization Laboratories Underused in Veterans Administration Hospitals: Better Planning and Control Needed" (HRD-76-168) examined the VA cardiac catheterization program and discussed the need for improved management of VA's policy for planning and controlling the expansion of its specialized medical services. Many VA cardiac catheterization laboratories were underused. Some laboratories unnecessarily provided this costly service, although it was available at nearby VA and community hospitals. In effect, VA did not follow its policy that specialized medical services, such as cardiac catheterization, be planned and provided on a regionalized basis to avoid duplicating or overlapping.

Report on PHS

A recent report (HRD-77-111) on the level and range of services provided by the PHS hospital system was issued on May 26, 1977, to the Chairman, Senate Committee on Appropriations. We addressed this issue to determine whether PHS was operating at the 1973 level as required by law. We believe that in considering funding for the PHS hospital system, the Congress should decide whether the Nation intends to realize the potential of this system as a resource for medical care at a reasonable, controllable cost. The Congress should consider the potential savings from providing health care to military dependents in federally controlled PHS facilities and the economies and efficiencies of PHS hospital participation in and cooperation with regional and local health planning and resource allocation organizations.

Multiagency reports

Our most recent audit efforts have concentrated on the opportunities available for the Federal health care delivery systems to effectively share certain costly specialized medical resources--cardiac catheterization laboratories and computed tomography scanners--and more effectively coordinate interagency planning.

Our report to the Congress entitled "Sharing Cardiac Catheterization Services: A Way to Improve Patient Care and Reduce Costs" (HRD-78-14, Nov. 17, 1977) said use levels varied widely at the nine DOD and VA catheterization laboratories in four geographic areas visited. Although VA had guidelines for planning catheterization laboratories, including recommended workload levels, DOD and PHS had no such guidelines.

We recommended that DOD, VA, and HEW develop uniform guidelines for planning and using Federal cardiac catheterization laboratories. We recommended that after the Federal guidelines are established, these agencies jointly analyze use levels of all their laboratories and adjust the way the service is provided so that it would be in accordance with the new guidelines. We suggested that at locations where the guidelines could not be met alone or through interagency sharing, consideration be given to closing Federal laboratories and obtaining the service from nearby civilian hospitals.

We also recommended that OMB oversee the efforts to develop these guidelines to be sure they were done in a timely manner and to insure that this diagnostic service was shared where patient care would be improved and cost savings result.

In another recent report to the Congress entitled "Computed Tomography Scanners: Opportunity for Coordinated Federal Planning Before Substantial Acquisitions (HRD-78-41, Jan. 30, 1978) we discussed the lack of a coordinated approach to planning and using scanners.

Neither DOD nor VA had formal guidelines and criteria to justify the need for and geographical placement of scanners. Also virtually no coordination took place between these two agencies in planning for scanners.

We recommended that the Secretaries of Defense and HEW and the Administrator of Veterans Affairs:

--Develop criteria for assessing and justifying the need for scanners and the most appropriate geographical placement.

--Establish a policy which would require, when possible, interagency sharing of scanners.

--Evaluate the feasibility and economies of using civilian capability before placing scanners in a Federal hospital.

In addition, OMB should oversee the efforts to develop a coordinated Federal approach to insure that it is developed promptly. We also recommended that the Congress explore the merits of limiting scanner acquisitions until such an approach is developed.

Our recent report concerning Federal health care in Hawaii ("Better Coordination Could Improve the Provisions of Federal Health Care In Hawaii," HRD-78-99, May 22, 1978) showed that although Federal health care there is generally readily available and accessible, facilities could be better used. Also there apparently is a unique opportunity available during the major renovation and construction project at the Tripler Army Medical Center to design a facility which will more closely meet the health care needs of all Federal beneficiaries in Hawaii.

Reports on use of medical resources nationwide

We issued a report on November 20, 1972, entitled "Study of Health Facilities Construction Costs" (B-164031(3)) pursuant to section 204 of the Comprehensive Health Manpower Training Act of 1971. This act directed us to study the feasibility of reducing the cost of constructing health facilities assisted under the Public Health Service Act. We identified and studied means by which health facility construction could be avoided by either reducing the demand for facilities or increasing their productivity. Means identified and studied included shared services and regional systems.

We found that sharing could free facilities for other purposes and could be effective in meeting demands for space without construction. Many hospitals, however, have been impeded from establishing sharing agreements because (1) physicians are reluctant to share hospital medical staff privileges, (2) economic incentives are lacking, (3) hospital medical staffs and administrators want to provide a full range of services, and (4) some communities insist on having such services readily available.

Authorities, we found, consider regional hospital systems to be an effective way of organizing and using scarce medical skills and facilities and of curbing rising costs. Communities, hospital officials, and physicians, however, have resisted the development of such systems because they want to maintain complete autonomy and to provide each community ready access to health services.

FEDERAL AGENCIES' EFFORTS TO BETTER USE MEDICAL RESOURCES

Until recently Federal agencies planned for acquiring medical resources and delivering health care only in terms of individuals for whom each agency had a primary health care responsibility. Therefore, DOD provided care to active duty military personnel; VA to veterans; and PHS to American seamen, PHS' commissioned corps, and Coast Guard personnel.

However, on June 17, 1977, headquarters representatives of DOD, VA, and HEW met to discuss DOD's plans for acquiring computerized tomography scanners in fiscal years 1977 and 1978 and the impact that these plans would have on the other Federal health care providers. Other purposes of the meeting were:

--To affirm a commitment by the participants to cooperative computerized tomography scanner planning, including coordinated development of criteria and standards. This approach included sharing such services when feasible.

--To affirm a top-level commitment to similar cooperation in planning for all highly specialized services and capital equipment investment.

--To identify contact points in each Federal agency and set the stage for working level contacts.

Following this meeting planning information was exchanged and the feasibility of sharing scanners as well as cardiac catheterization laboratories between DOD and VA was considered. Subsequently, DOD gave VA lists describing the specialty services and medical capabilities at Army, Navy, and Air Force hospitals in the United States. These lists were to be used with VA's list of specialized medical services and programs to help select resources that appear likely for possible cooperative planning and sharing. In addition, PHS indicated its willingness several times to exchange services with other Federal agencies. Subsequently an interagency Federal Health Resources Sharing Committee was created.

An overall agreement (charter) to share medical resources was drafted by DOD, VA, and PHS officials. This charter has recently been approved by all agencies concerned. The approved charter directs the Committee to identify and eliminate obstacles to sharing, to prepare guidelines for sharing and other cooperative arrangements for the agencies, to recommend actions to be taken when obstacles are not within the authority of the agency heads to resolve, and to establish subcommittees to deal with specific areas of concern.

In addition, DOD and VA regionalization programs have attempted to make better use of the medical resources within their agencies.

DOD'S ARMED FORCES REGIONAL HEALTH CARE SYSTEM

On September 5, 1973, the Deputy Secretary of Defense directed the Secretaries of the Army, Navy, and Air Force to implement the Armed Forces Regional Health Care System. The purpose of the system is to improve the delivery of health care to all DOD beneficiaries by increasing productivity and achieving economies in resources while improving patient/staff satisfaction and insuring that no degradation of quality ensues. The continental United States was divided into 13 military medical regions based on DOD population and the location of specialty treatment facilities.

The Surgeons General of the Army, Navy, and Air Force informed us in September 1976 that under this form of regionalization, the most significant accomplishments to date were the initiation and completion of triservice studies on (1) comparability of health resources between the military services, (2) patient regulation, (3) optical services, and (4) blood programs. However, according to the Surgeons General, more significant than all of these accomplishments was the start of a program of continued contact and information exchange between uniformed medical treatment facility personnel at all levels and in all specialties.

Triservice regionalization continued until December 1976 under the same organizational structure established in September 1973. On December 28, 1976, the Secretary of Defense established a DOD Health Council to provide coordination, standardization, and oversight to DOD's health service programs. The Council was the "central entity" recommended in the Military Health Care Study (see p. 48) to coordinate the planning and allocating of medical resources. The Council is composed of the Assistant Secretary of Defense (Health Affairs) (the chairman), the Surgeon General from each military department, and one representative each from the Joint Chiefs of Staff and the Uniformed Services University of the Health Sciences.

The Council has assumed a responsibility in regard to managing medical resources that has not been previously assigned in DOD. In addition to being concerned over DOD's resources, the Council has established objectives which, if achieved, should help make the best use of all resources--both Federal and non-Federal--in and around the areas served by the numerous military hospitals and clinics. In January 1978, the staff which supported the Council was disbanded because of actions initiated by the Office of the Secretary of Defense.

Since March 1, 1977, all requests for procuring medical equipment with a total cost of $100,000 or more must first be forwarded to the Council for review. Requests must be supported by a cost-benefit analysis and be coordinated with other military and Federal hospitals in the same geographical area. Requests also require specific documentation, including the identification of (1) similar local capabilities in other Federal and civilian facilities and (2) efforts toward seeking interagency sharing agreements. Also, since October 1, 1977, the Council is required to review proposals to establish, close, or expand major medical services or capabilities. This review complements the equipment review process. These actions are similar to the review procedures within the civilian sector under the National Health Planning and Resources Development Act of 1974.

Finally the Council has recognized that the original 13 regions are no longer appropriate. The Council considered various boundary schemes and eventually established nine military medical regions. Redesignation of these boundaries is the first step toward an overall revitalization of the regionalization program and a renewed effort to achieve program objectives.

A DOD directive has been drafted incorporating the policy and concept of operation for the Armed Forces Regional Health Services System. The directive provides guidance in terms of the system's overall objectives, organization, and responsibilities. The draft specifically provides for including VA and PHS representatives in regional review committees' meetings and the establishment, as required in each region, of a Regional Programs Staff and certain standing subcommittees to focus upon specific responsibilities. The approval of this directive is pending until the ultimate reorganization of health affairs in DOD and the role of the Council is resolved.

VA REGIONALIZATION PROGRAM

VA has implemented a regionalized approach for delivering health services by dividing the country into 28 medical districts. The primary objective of regionalization is to improve patient care through the most effective and efficient use of VA medical resources. VA's regionalization concept recognizes that sophisticated, expensive, specialized medical services cannot be provided at each VA facility; however, VA beneficiaries can usually be referred to another VA facility within the medical district to receive the services. Interdistrict referrals occur when needed specialized services are not available within each medical district.

According to VA officials, the regionalization of the VA's Department of Medicine and Surgery continues to be a major departmental policy. It encompasses growing field authority with broadening medical district responsibilities, VA Central Office planning with a medical district focus, and medical district planning and budgetary management to maximize resource use. This approach in each medical district to health care delivery, through a district executive council led by a medical district director, is responsible for assuring the availability of programs with optimum productivity, evaluating and monitoring programs, distributing resources, and planning to meet present and future needs.

In December 1976 regionalization was instituted within VA on a systemwide basis. Subsequently all 28 districts received a consolidated budget for fiscal year 1978 and were responsible for recommending personnel ceilings and the distribution of workloads and resources. In previous years such funding and functions were done on a hospital-by-hospital basis. This revised method of budgeting will require continual internal monitoring and the eventual recommendation for reallocation of resources. This will allow local flexibility to meet the changing requirements of health care delivery in the districts.

According to VA officials, accomplishments under the intra-VA regionalization program include the uniform interpretation and application of policy statements, directives, and reporting procedures; increased use of educational and training opportunities; medical district assessment of program needs; prioritization of resource allocations for equipment, construction, and maintenance projects and programs; realignment of bed services within districts to provide easier and more ready access to services; avoidance of duplication of services; increased intra-VA exchange and use of professional expertise and clinical support capabilities; and recognition and designation of employees who have met high performance standards.

According to VA's response to the National Academy of Sciences report (see p. 50) a secondary objective of the overall VA regionalization program is to improve the use of medical resources and facilities between VA and community health providers. Under this program, contracts for sharing allow expanded use of community medical resources and allow health institutions in the community to use VA's specialized resources.

INTERAGENCY SHARING

We requested lists from DOD, VA, and PHS headquarters offices of the interagency sharing arrangements each agency had. However, at January 1978, a complete list was not available from every agency. Therefore, though agencies are exchanging services under various interagency arrangements, we will discuss only those arrangements brought to the attention of the Congress in the last 18 months.

The only recurring report made to the Congress on medical resources sharing is an annual report by the Administrator of Veterans Affairs as required by 38 U.S.C. 5057. This report contains only the formalized sharing agreements (38 U.S.C. 5053) under which VA receives or provides services. VA does, however, provide services under the Economy Act.

In VA's fiscal year 1977 annual report on sharing, 93 VA health care facilities were listed as sharing their resources with or using the resources of other Federal and non-Federal health care facilities. Two hundred twenty-five sharing agreements were required for these services to be shared. The total cost of the services exchanged under these agreements amounted to about $16.1 million. Of this, about $6.25 million represented the cost of services furnished by VA and $9.87 million represented the cost of services furnished to VA. However, according to the report, only 4 of the 225 agreements were with other Federal facilities. Under these sharing agreements, services costing only about $9,100 were provided to VA by another Federal agency and services costing only about $17,200 were provided to other Federal agencies by VA.

The only other recent document which cited other medical resources shared between Federal facilities was a December 29, 1976, letter report to the Chairman, Senate Appropriations Committee, from the Assistant Secretary of Defense (Health

Affairs) concerning the feasibility of sharing Federal medical facilities. This letter stated that in calendar year 1975 DOD had allocated an average of 123 beds per day for VA beneficiaries. VA, during the same period, provided an average of 283 beds per day for inpatient care for DOD beneficiaries. An attachment to the letter showed that 166 beds in certain Army, Navy, and Air Force hospitals had been requested by VA for use in fiscal year 1977 for VA beneficiaries. However, we were told by VA's Director, Medical Administration Service, that DOD's allocation of beds for VA beneficiaries are really "phantom beds," which normally are used only in emergencies. Furthermore, an official of DOD's Armed Services Medical Regulating Office said the DOD beneficiaries placed in VA hospitals by that Office are usually active duty personnel who will soon be separated from active duty because of disability or retirement. These beneficiaries would, for the most part, eventually become the primary responsibility of VA and therefore are referred to VA hospitals by DOD before separation and accepted by VA in order to provide continuity of care.

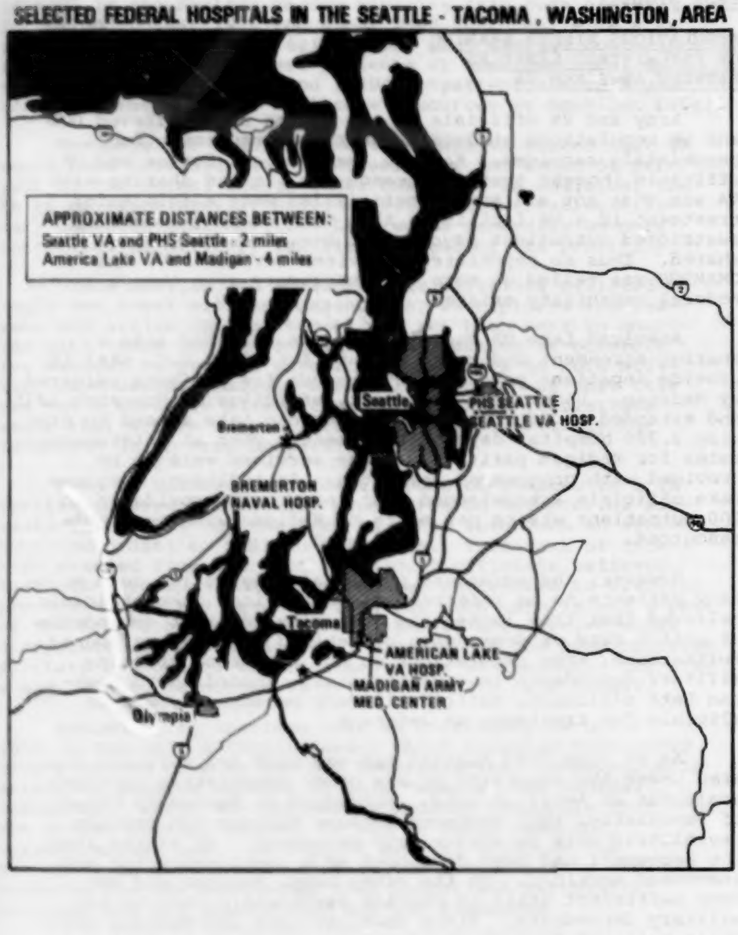
CASE STUDIES OF SELECTED OPPORTUNITIES--AND RELATED OBSTACLES--TO INTERAGENCY SHARING

Numerous opportunities exist for interagency sharing of medical resources, in addition to those identified in previous GAO reports. (See app. II.) The potential of these opportunities was largely unrealized for various reasons. Obstacles to sharing are the primary focus of these case studies and our study conducted at the request of the Chairman, House Appropriations Committee.

These case studies illustrate inconsistencies within and between agencies in the interpretation of laws and regulations. They do not always provide a clear, understandable and logical reason why sharing did not occur. Rather, they often raise questions, but in our opinion, accurately illustrate the confusion among Federal health facility managers about their authority and responsibility to share. We believe that these examples effectively demonstrate the need for a clear and concise Federal legislative mandate on sharing Federal medical resources and the corresponding need for implementing procedures.

The case studies are presented by the following geographical areas: Seattle-Tacoma, Washington, area; San Francisco, California, area; Los Angeles, California, area; San Diego, California, area; Tucson, Arizona, area; Albuquerque, New Mexico, area; Colorado-Wyoming area; Temple, Texas, area; Tampa, Florida, area; Miami-Key West, Florida, area; Lexington, Kentucky, area; and New England area.

SELECTED FEDERAL HOSPITALS IN THE SEATTLE - TACOMA, WASHINGTON, AREA


APPROXIMATE DISTANCES BETWEEN:
Seattle VA and PHS Seattle - 2 miles
America Lake VA and Madigan - 4 miles
Seattle
PHS SEATTLE
SEATTLE VA HOSP.
Bremerton
BREMERTON NAVAL HOSP.
Tacoma
AMERICAN LAKE VA HOSP.
MADIGAN ARMY MED. CENTER
Olympia

CASE STUDY 1

REGULATIONS HINDER SHARING OF PSYCHIATRIC SERVICES BETWEEN ARMY AND VA

Army and VA officials in the Tacoma area believed DOD and VA regulations hindered a sharing arrangement for psychiatric services. Madigan Army Medical Center and VA officials thought that one reason for limited sharing with VA was that not all Army beneficiaries were eligible for treatment in a VA facility. Also VA's sharing authority restricted outpatient psychiatric services from being shared. Thus no psychiatric services were shared, and CHAMPUS was relied on more than necessary even though excess Federal capability existed.

American Lake VA Hospital, Tacoma, entered into a sharing agreement under the Economy Act (31 U.S.C. 686) to provide inpatient psychiatric services for patients referred by Madigan. Under this agreement, effective in November 1975 and extended to September 1977, American Lake agreed to provide 2,700 hospital days of treatment a year at interagency rates for Madigan patients. These services were to be provided with programmed resources. In addition, American Lake officials acknowledged that they could provide up to 100 outpatient visits per month to Madigan with available resources.

However, the agreement permitted only active duty military patients to be referred, since American Lake officials believed that they lacked the authority to treat dependents of active duty or dependents of retired military personnel. Furthermore, Army regulations do not authorize treating military dependents in a VA hospital. According to Amercan Lake officials, retired military personnel would be eligible for treatment as veterans.

As of June 1977 Madigan had not used any services covered under the agreement or any other psychiatric services available at American Lake. According to Madigan's Chief of Psychiatry, this occurred because Madigan can provide psychiatric care to active duty personnel. He stated that the agreement had been developed as a contingency for any increased workload. On the other hand, Madigan did not have sufficient staff to provide psychiatric care to all military dependents. Since American Lake and Madigan officials believed that VA could not provide care to military dependents, patients sought care from civilian sources under CHAMPUS.

The total cost of psychiatric care provided under CHAMPUS in the Seattle-Tacoma vicinity (zip code areas) for calendar year 1976 was about $500,000. While data is not available to show precisely how much savings could have resulted in treating these patients at American Lake, up to 2,700 inpatient days and 1,200 outpatient visits a year could be provided with available resources at American Lake.

The Chief of Staff at American Lake VA stated that VA could have provided outpatient services for about 56 percent of the normal charge under CHAMPUS. In addition, the Chief of Psychiatry at Madigan stated that treating military dependents at American Lake would generally be more convenient to military families because of its proximity.

Since Madigan and American Lake officials believed VA could not treat military dependents, we explored the reasons why active duty personnel had not been sent to American Lake under the sharing agreement, making it possible for Madigan to provide psychiatric services to more military dependents. Madigan officials informed us that this was not a workable alternative because Army regulations state that active duty military have first priority for treatment in an Army hospital.

Even if military dependents could be treated in a VA facility, current budgetary procedures do not provide adequate incentives for the Army to enter into such an agreement, according to Madigan officials. This lack of incentive stemmed from the fact that local officials believed that care provided under CHAMPUS was restricted to civilian providers. In any case the cost for such care is not a part of the Army's budget. CHAMPUS payments are covered under a separate DOD appropriation. However, if the Army referred military dependents for treatment in a VA facility, the Army would have to reimburse VA from its health care budget.

According to American Lake VA officials, 38 U.S.C. 5053 is the only authority under which American Lake could have provided care to all DOD beneficiaries. However, this authority permits sharing of only "specialized medical resources," which are defined as medical resources that are either costly, scarce, or can be fully used only through mutual use. VA's Chief Medical Director has authority to define what constitutes a specialized medical resource and has determined that outpatient psychiatric services are not specialized medical resources.

CASE STUDY 2

INFLEXIBLE INTERAGENCY REIMBURSEMENT RATES HINDER SHARING

Renal dialysis

The Seattle VA Hospital had a contract with a private hospital to perform renal dialysis for veterans in Tacoma, about 35 miles from Seattle VA but only a few miles from Madigan. The contract called for 906 treatments a year at $133 per treatment. During calendar year 1976, the cost was about $120,000.

At the time of our review, Madigan's renal dialysis unit was treating two patients. Madigan had the equipment and personnel to include VA patients in its dialysis program if its renal dialysis ward were remodeled. Remodeling would be necessary to provide for the optimum use of present equipment and staff. It would cost about $15,000 and was being planned. Madigan's Chief of Renal Dialysis and Comptroller stated that they would be willing to treat VA's patients if Madigan could be adquately reimbursed.

Army regulations require that Madigan charge as well as pay interagency rates when sharing inpatient and outpatient medical services with another Federal facility. Interagency rates are set by each agency and approved by OMB. The interagency rate in fiscal year 1977 for inpatient care in a DOD facility was $168 a day, and the outpatient rate was $20 a visit. Madigan officials stated that they were not aware of any authority that allows for variations from the interagency rates for medical procedures directly involving the patient.

The Comptroller stated that the interagency outpatient reimbursement rate of $20 is inadequate. He also stated that Madigan does not directly receive any of this amount back from Army headquarters. He believed Madigan would, as a minimum, need to be reimbursed for all renal dialysis supplies, including those used by the two Madigan patients. He stated this would cover Madigan's true marginal costs in providing the services.

Seattle VA's Chief of Renal Dialysis said expendable renal dialysis supplies cost about $60 a treatment. However, Army regulations required that Madigan not charge VA more than the above interagency rates. Renal dialysis requires 4 to 9 hours of treatment and, since the patient is not admitted to the hospital, treatment is usually classified as outpatient treatment. In addition, if Madigan charged the inpatient rate, sharing would not be advantageous to VA since VA's current contract rate is $133 per treatment. But if Madigan could be reimbursed for supplies, VA's costs would be more than cut in half, from $133 a treatment to about $60.

We also inquired whether VA could purchase the supplies and send them to Madigan to be used in treating VA patients. A Madigan official informed us he was unaware of any Army regulations that would permit such an arrangement.

Radiology

Madigan had about 50 percent of its authorized radiologists. On the other hand, nearby American Lake VA Hospital employed a part-time radiologist under a personal services contract. Both American Lake and Madigan were receptive to American Lake's obtaining a full-time radiologist to share with Madigan in exchange for some needed medical services.

Madigan and American Lake officials were unsure how to pursue this type of arrangement in view of regulation complexities. An American Lake official believed a full-time radiologist position would have to be justified to VA headquarters on the basis of VA patient workload. Madigan officials believed they would have to pay and be reimbursed interagency rates in sharing with American Lake. Because of the uncertainties on both sides concerning the correct way to proceed on this matter, the services of a full-time radiologist were not obtained.

CASE STUDY 3

CHAMPUS PROCEDURES DO NOT ENCOURAGE OPTIMAL USE OF FEDERAL FACILITIES

Dependents of military personnel, military retirees and their dependents, and dependents of deceased military members may receive medical care either in their designated medical system or in a civilian medical facility under CHAMPUS. Generally, for inpatient treatment under CHAMPUS, these patients must obtain a certificate stating that needed care is unavailable in a uniformed service facility within a 40-mile radius. A similar certificate is not required for outpatient care because such services are not required to be performed in a uniformed service facility.

We obtained data from CHAMPUS headquarters on the types of medical services being provided to CHAMPUS patients in most of western Washington. To determine if these services could have been provided by local Federal facilities, we compared these procedures with those at facilities having some unused capacity. While this analysis did not allow us to determine how many of these CHAMPUS patients could have been treated in Federal facilities, it indicated care is being obtained under CHAMPUS despite the unused capacity of nearby Federal facilities.

For example, Seattle VA, Seattle PHS, and Madigan Army Medical Center all had some excess capacity in their nuclear medicine departments. However, projections from the CHAMPUS data disclosed that about $25,000 of nuclear medicine diagnostic procedures had been procured in selected western Washington zip code areas during calendar year 1976. Similarly CHAMPUS paid an estimated $6,500 for electroencephalograms even though three hospitals reviewed acknowledged excess capacity. In a previous case study (see p. 67), almost $500,000 of psychiatric care was also provided through CHAMPUS in the Seattle-Tacoma zip code areas, even though a VA psychiatric facility in the area had available capability.

Furthermore, PHS regulations do not allow PHS to contract for hospitalization of CHAMPUS beneficiaries in a non-PHS hospital. As a result, PHS cannot take advantage of orthopedic surgery at the nearby VA hospital.

Between February and May 1977, 13 PHS patients requiring nonemergency orthopedic surgery were referred to a civilian facility under CHAMPUS. The Seattle VA Hospital, 2 miles from PHS, performs orthopedic surgery. The Chief of Staff at the VA hospital stated that VA could have absorbed some of these PHS patients into their orthopedic surgery schedule. In addition, he stated the VA hospital could have provided sufficient postoperative care for them until they could be transferred to PHS and that the hospital needs to be reimbursed a sufficient amount to cover the costs of the services.

CASE STUDY 4

BUDGETARY CONSTRAINTS LIMIT SHARING OPPORTUNITIES

VA and DOD radiation therapy

In VA's Medical District No. 28, there are nine VA facilities in Washington, Oregon, and Idaho. None have in-house capability for radiation therapy used in treating cancer. VA patients in Seattle and Portland have received radiation therapy at nearby medical schools. Other district facilities transferred 54 patients to the Martinez VA Hospital near San Francisco during calendar year 1976.

In January 1977 the Chiefs of Staff at VA hospitals within Medical District No. 28 recognized the need to obtain this service from a new source within the district. Therefore, the district attempted to obtain this service from Madigan Army Medical Center, the only Federal facility with radiation therapy capability within the district. The Deputy Commander at Madigan said Madigan had equipment to accommodate non-DOD patients, but not the staffing. He therefore responded to VA's request by stating:

> "Due to present staffing limitations at this facility, to include radiation therapy technicians and laboratory technicians, I must state, with regret, that we cannot meet your requests. Additionally, our next higher headquarters has not assigned us the mission of supporting the Veterans Administration in this matter." (Emphasis added.)

As a result of the above response, accompanied with an increased need to obtain a cost-favorable source for radiation therapy within the district, the VA's Medical District No. 28 Director informed us that VA is considering a long-range plan to develop the capability for in-house radiation therapy requiring an equipment cost alone of $500,000.

VA and PHS angiogram procedures

Another element that was a budgetary constraint to sharing is VA's procedure which restricts sharing to programmed resources. This procedure resulted in less than optimum use of angiogram equipment.

Both Seattle VA and PHS have angiogram units (sophisticated X-ray equipment used for diagnostic purposes). Procedures are performed by injecting dye and chemicals into selected areas of the body and using the angiogram (X-ray) equipment to film the areas under examination. Seattle VA's modern angiogram unit can perform very complex angiographic procedures. VA's equipment cost about $500,000 while PHS' equipment cost $250,000. VA's equipment was being used at 80 percent of capacity, based on 8 use-hours a day. In March 1977 PHS installed its own unit. The equipment was originally purchased in 1972 but was not installed until 5 years later due to lack of space-remodeling funds. Remodeling and installation cost about $30,000.

PHS headquarters officials said that the PHS equipment was purchased to be used for angiograms and a variety of other radiographic diagnostic purposes. PHS expects to use the equipment about 8 to 13 hours a week for angiograms and a substantial number of additional hours for other radiographic diagnostic procedures. PHS believes that angiography is an essential service in any modern general hospital if adequate diagnostic services are to be provided for acutely ill patients and if patients can not normally be transferred to other facilities for angiograms.

Nevertheless, between November 1975 and March 1976, VA performed most of PHS' angiograms. In May 1976 PHS' need for angiograms increased, which caused scheduling disruptions at VA. As a result, VA imposed procedural guidelines which restricted PHS' use of VA's specialized X-ray procedures to three PHS patients per week. PHS patients that could not receive angiographic services at VA were sent to civilian hospitals. According to PHS' Chief of Radiology, this represented about two procedures a week. The Chief of Radiology, VA, told us that VA could have performed the two additional tests per week during other than normal working hours.

However, this alternative was not supported by VA or pursued by PHS because sharing procedures restricted sharing to resources that have been justified on the basis of veterans' care but which were not being used to their maximum extent during normal working hours. Therefore, Seattle VA believed it lacked budgetary authority to expand its staffing resources solely to serve PHS' needs.

We were told in May 1977 that Seattle VA was procuring an additional angiogram unit to be used in conjunction with VA's cardiac catherization laboratory. This equipment cost an estimated $333,000. Seattle VA officials said this equipment could also be used for PHS angiogram procedures. However, availability of staffing would still be a problem if PHS' needs could not be met during normal working hours.

CASE STUDY 5

EMPHASIS ON INTRAAGENCY PLANNING RESTRICTS OPTIMUM USE OF FEDERAL HEALTH CARE RESOURCES

Electron microscope

Madigan Army Medical Center's pathology department requested about $60,000 worth of new electron microscope equipment even though Seattle VA's equipment could absorb the additional workload. No attempts were made to determine the capacity of other local Federal facilities.

Madigan has electron microscope capability, which is used to study tissue specimens for diagnostic purposes. Madigan officials told us that during 1975 and 1976 the equipment had been used only a few hours a week. However, Madigan's Chief of Pathology stated that because the equipment is aging, he has requested it to be replaced at a cost of about $60,000.

Seattle VA has an electron microscope that cost $91,000 and is operated about 4 hours a day. Seattle VA is doing electromicroscopy procedures for PHS at no charge because of the small increase in time and resources required to process additional procedures. Furthermore the Chief of the Electron Microscope Section at Seattle VA stated that he would like to do Madigan's procedures because of the need for additional work to support Seattle VA's training programs. Seattle VA is willing, he said, to do these tests at no cost to Madigan.

Echocardiogram units

Four Federal facilities in the Seattle-Tacoma area had echocardiogram equipment;,none was fully used based on a 40-hour workweek. Echocardiograms are used as an aid for locating and diagnosing cardiovascular problems. The equipment is normally operated by a technican, and each procedure takes about 30 minutes to 1 hour (or, conservatively, about 40 procedures per week). The following table shows that echocardiogram equipment at Federal facilities was not being fully used and that two facilities plan to upgrade present capacity.

Federal facility	Estimated hours of use per week	Plan to procure new equipment	Cost of new equipment
Seattle VA	30	Yes	$13,020
Madigan Army Medical Center	12-15	Yes	44,500
American Lake VA	2-3	No	
PHS Seattle	5-9	No	

Sharing between American Lake and Madigan would eliminate Madigan's need to purchase a new echocardiogram unit. Furthermore, according to the technican at American Lake, if the two facilities shared the equipment, American Lake's could be upgraded for about $23,000 versus $44,500, the cost of a new unit at Madigan.

Electroencephalogram units

The electroencephalogram units at Madigan and American Lake are underused. Interagency coordination might have prevented acquiring some of this duplicate equipment.

American Lake has electroencephalogram equipment, which detects and records brain waves, but does not have a technican to operate it. Consequently, at the time of our review, it was sending patients about 45 miles to Seattle VA. Three patients were sent during a 5-week study period.

Madigan, 4 miles from American Lake, has two electroencephalogram units and was planning to add another unit. Equipment costs range from $8,000 to $15,000. The new unit was expected to increase the workload capacity. The Chief of Madigan's electroencephalogram unit stated that it is doing some procedures for American Lake and could take on additional VA workload if asked.

Nuclear medicine scan units

Seattle VA, Seattle PHS, and Madigan all have excess nuclear medicine capability. Seattle VA has three units costing a total of about $240,000, and is doing some procedures for American Lake. During the first half of fiscal year 1977, Seattle was operating below VA's minimum utilization standards for nuclear medicine capability. Seattle is doing 6 to 8 procedures daily but has a maximum capability of 18 procedures daily. Madigan has two nuclear medicine

best copy available

units each costing between $125,000 and $150,000. It has some excess capability and is doing about 45 scans per month for American Lake on an informal basis.

In June 1976 the local VA regionalization council met to discuss the feasibility of developing a nuclear medicine laboratory at American Lake. In June 1977, $270,000 was approved by VA's Central Office for this project which had high priority for implementation as part of VA regionalization efforts. The excess capacity of the other three facilities was not adequately considered.

- - - -

In commenting on this case study, PHS headquarters officials told us that restrictions on the purchase of equipment should be applied to areas of high-cost technology where serious questions of cost effectiveness arise. In their opinion, all the examples cited in the case study are necessary diagnostic equipment in a modern general hospital which operates as a regional medical center, such as each of the PHS hospitals. As such, PHS believes that they are indispensible to providing basic medical services to patients in that hospital's region. However, they agree that such services could be shared.

CASE STUDY 6

REGULATIONS RESTRICT PATIENT MOVEMENT BETWEEN FEDERAL FACILITIES

VA and DOD regulations required some patients to be transported to hospitals outside the area so they could be treated within the same agency. Some patients were sent several hundred miles for treatment even though a nearby Federal facility had the capability. The restrictions may result in less than optimal patient care and in underuse of resources. In addition, patients may be needlessly separated from their families for long periods.

VA spinal cord injury patients

Seattle VA transported an estimated 19 spinal cord injury patients to California during a year's time, even though PHS Seattle has a spinal cord injury center. The VA and PHS hospitals are 2 miles apart. Further, Seattle VA is planning to construct a spinal cord injury center without considering sharing PHS capability.

A Seattle VA official said sharing could not be considered because of regulation restrictions. The regulation states, in part:

> "A patient hospitalized by the VA may develop a need for treatment which the hospital is not staffed and equipped to perform * * *. A transfer to a non VA hospital is restricted to those patients developing a bona fide medical emergency which precludes moving the patient to another VA hospital."

In one instance, a patient may not have received optimal care and local Federal facilities were not fully used. A Coast Guard member injured on active duty received spinal cord treatment from a local community hospital in Miami, Florida, at a cost of over $13,000. The Miami PHS clinic responsible for Coast Guard beneficiaries had no capability to treat spinal cord injuries; hence the referral to the community facility. However, Miami VA's spinal cord injury center could easily have treated the beneficiary within existing capacity. VA's charges--using interagency reimbursement rates of $116 an inpatient day--would have been about $7,000 for the same period, a savings of over $6,000. PHS did not consider contacting VA for the services, however.

After the initial treatment in Miami, the patient requested to be transferred to a Federal facility near his family in the Seattle area. Before discharge from active duty, he was admitted to Seattle VA. Seattle VA was selected because (1) it was near his home and (2) DOD regulations, applicable for all uniformed service beneficiaries, require that servicemen with permanent physical disabilities be discharged to VA for rehabilitation. Fifteen days after arrival at Seattle VA, he was officially discharged from the Coast Guard and became a VA beneficiary.

Before and after the patient was admitted to Seattle VA, he was told he needed further spinal cord injury treatment. However, in Seattle he was informed that he would have to go to VA spinal cord injury center in California. He refused to go because he did not want to leave his family. A Seattle VA official stated that the VA regulation noted above had precluded the patient from being transferred to a non-VA facility. He further informed us that since the patient was in the hospital for rehabilitation, he could not be classified as an emergency case, which precluded movement to a non-VA hospital.

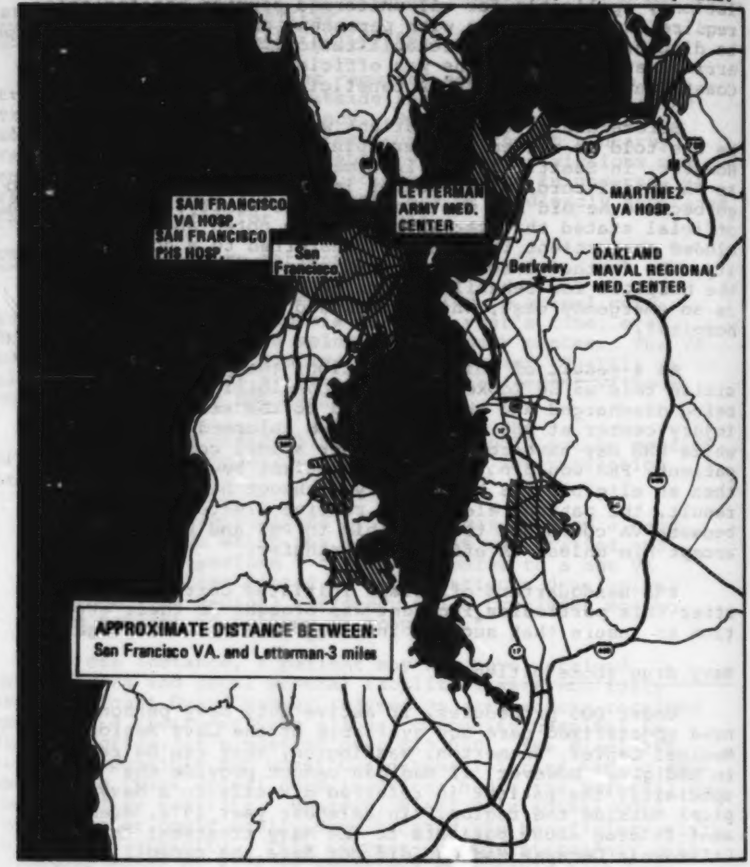
As a result of this restriction, the patient's VA physician told us he looked into the possibility of the patient being discharged and then admitted to the nearby spinal cord injury center at PHS. He stated PHS informed him that, while PHS may have room for another spinal cord injury patient, PHS could not admit the patient because he was not then an eligible PHS beneficiary although he had been. As a result, the patient elected to receive limited care at VA because VA could not transfer him to PHS and PHS could not accept him unless VA effected a transfer.

PHS headquarters officials initiated corrective action after this particular incident was brought to their attention to insure that such an incident does not occur again.

Navy drug abuse patients

Under DOD procedures, if active duty Navy personnel need specialized care not available at the Navy Regional Medical Center, Bremerton, Washington, they can be referred to Madigan. However, if Madigan cannot provide the specialty, the patient is referred directly to a Navy hospital outside the region. In calendar year 1976, Bremerton sent 16 drug abuse patients to the Navy treatment center in California because Madigan did not have the capability to provide care for these patients. No attempts were made to seek treatment at nearby American Lake VA, which specializes in drug abuse and could have treated these patients within programmed resources.

SELECTED FEDERAL HOSPITALS IN THE SAN FRANCISCO, CALIFORNIA, AREA


LETTERMAN ARMY MED. CENTER
MARTINEZ VA HOSP.
SAN FRANCISCO VA HOSP.
SAN FRANCISCO PHS HOSP.
San Francisco
Berkeley
OAKLAND NAVAL REGIONAL MED. CENTER

APPROXIMATE DISTANCE BETWEEN:
San Francisco VA. and Letterman-3 miles

CASE STUDY 7

LACK OF GUIDANCE PREVENTS SHARING BETWEEN VA AND DOD HOSPITALS

For 1-1/2 years San Francisco area VA and DOD officials negotiated unsuccessfully to share medical services between Federal hospitals. Many obstacles were cited, but the primary obstacle was a lack of DOD guidance on interagency sharing. Through individual initiative some progress toward VA-DOD sharing had been made, but officials were concerned that if precise guidance was not provided and other obstacles removed, it was doubtful that any great amount of sharing would occur.

VA's first formal contact with DOD occurred in March 1976, when VA proposed a sharing program beginning with DOD's radiation therapy capability. VA become interested in sharing with DOD hospitals when it found that all three major DOD facilities in the area--David Grant Medical Center, Travis Air Force Base; Letterman Army Medical Center; and the Naval Regional Medical Center, Oakland--had extensive radiation therapy capability. Most of VA's radiation therapy was being performed at the University of California Medical Center, San Francisco, and Martinez VA Hospital, the only VA hospital in the area with radiation therapy capability. Martinez VA's radiation therapy facilities, however, would have needed major upgrading to handle the entire VA workload. VA officials thought that sharing DOD's radiation therapy facilities might relieve some of the load without large VA expenditures and might save some money being spent at the university.

San Francisco VA officials estimated about $208,000 was being spent annually at the university for VA patient radiation therapy. The university was paid for these services from San Francisco VA's own operating budget, so San Francisco VA had an incentive to save money. Although rates had not been negotiated with nearby Letterman, VA officials expected them to be substantially lower than those of the university. In fact, a San Francisco VA official estimated about half the annual expenditures could be saved by shifting part of the workload to Letterman.

As a result of the March 1976 contact with the military, VA, at a meeting with the DOD triservice regionalization group on June 25, 1976, proposed sharing of facilities and services between VA and DOD. Initially DOD treatment of radiation therapy patients was to be emphasized.

According to VA officials, the DOD participants were friendly and attentive, but not very enthusiastic. DOD officials felt that the VA presentation had been an initial exploratory step toward a mutually beneficial exchange of information and services. DOD did not make any direct commitments, however, primarily because guidance was not available on how to proceed with interagency proposals.

Consequently, the Northern California Military Medical Region requested guidance in a July 1976 report to the regionalization coordinating body in Washington, D.C.--the Military Medical Regional Coordinating Office (MMRCO). The report stated:

> "We expect to continue exploration and exchange of information with the VA: however, guidance from the MMRCO would be helpful in establishing procedures prior to exchanging or providing services." (Emphasis added.)

No guidance had been provided as of August 1977, over 13 months later. As a result, VA and DOD had not exchanged any services. In the interim VA was invited to attend DOD professional counterpart meetings and was included on a list of area Federal medical capabilities, but these achievements--resulting from extensive individual initiatives --were the extent of interagency activities. Letterman officials believed an agreement could have been worked out if proper guidance and procedures from DOD had been available and other obstacles--including reimbursement constraints--had been eliminated.

Officials from all three DOD hospitals cited two major obstacles to sharing with VA: (1) the lack of guidance and (2) a lack of incentives to share. The officials believed that to give the military an incentive to share, the providing hospitals must be directly reimbursed. According to these officials, headquarters collect payments for inpatient and outpatient services. However, no inpatient or outpatient funds collected are returned to the hospital to help defray costs of additional supplies or staff.

VA and DOD officials believed potential for several sharing agreements existed that could be beneficial, but probably not much would occur until sharing procedures are clarified and the reimbursement obstacles eliminated. Among the sharing opportunities mentioned were:

--Radiation therapy. In addition to the San Francisco VA/Letterman example, Livermore and Martinez VA

pages tightly bound

Hospitals could use either David Grant Medical Center or the Naval Regional Medical Center, Oakland.

--Dermatology, rehabilitation, and physical medicine services. San Francisco VA could provide these services to military patients.

--Renal dialysis. Letterman could provide this service to other Federal agencies.

--Biomedical engineering support. This service could be shared between VA, DOD, and PHS.

--Laboratory services. Such services could be shared between VA, DOD, and PHS depending on each laboratory's capabilities.

A VA official told us that any needed service at Federal facilities should be shared. He believed no constraints should exist when the Government and all Federal patients would benefit.

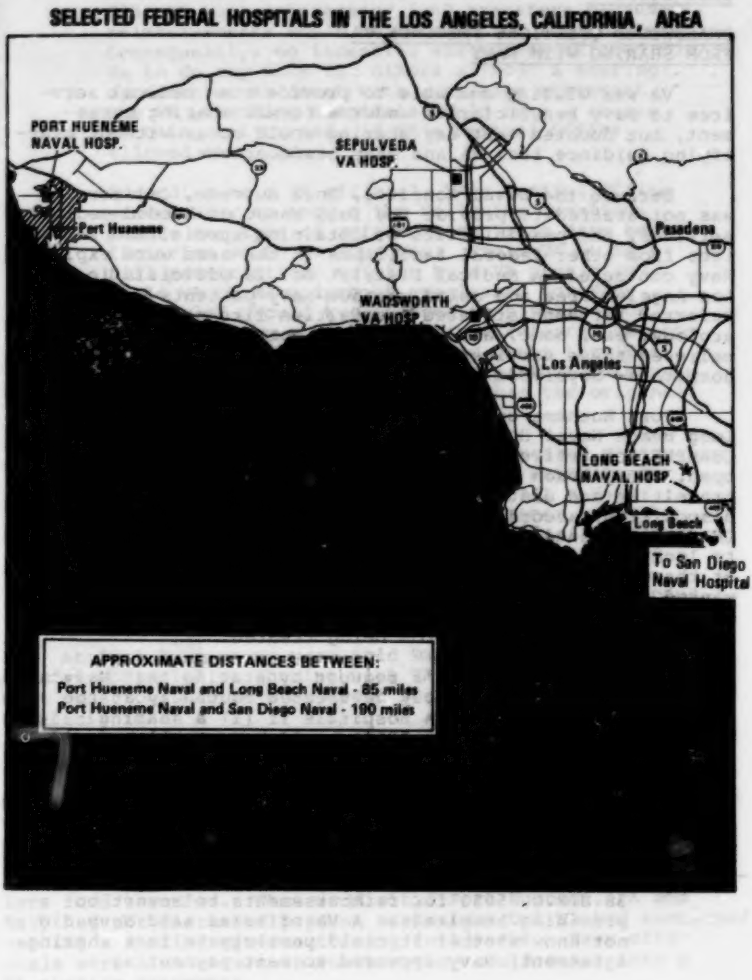
VA officials described certain other obstacles to interagency sharing and offered these suggestions to overcome them.

1. VA has authority to share services with DOD under 38 U.S.C. 5053 on a full cost reimbursement basis. A VA official told us, however, that DOD usually talks about reimbursement in terms of intergency rates, not full cost. VA needs to be reimbursed under a sharing agreement to have funds collected revert to the providing hospital. Without the local reimbursement, no incentive exists to share services. VA officials feel a standard reimbursement mechanism is needed, with funds collected remaining at the providing level.
2. Some patients are restricted from being treated in VA facilities. For example, VA cannot routinely treat DOD dependents without a 38 U.S.C. 5053 sharing agreement. One legal entitlement allowing all Federal beneficiaries to be treated in VA, DOD, and PHS hospitals with the necessary facilities and capabilities is needed.
3. No legal justification exists for spending money at a VA hospital to care for other Federal beneficiaries. Funds collected from other Federal agencies should be used to provide supplies, increase staffs, and upgrade equipment when excess

capabilities exist. Duplication and underuse of services and facilities would subsequently be reduced.

4. VA's Central Office has been overly restrictive in interpreting what constitutes a specialized medical resource and therefore restricts eligibility for sharing under 38 U.S.C. 5053.

SELECTED FEDERAL HOSPITALS IN THE LOS ANGELES, CALIFORNIA, AREA


PORT HUENEME NAVAL HOSP.
SEPULVEDA VA HOSP.
Port Hueneme
Pasadena
WADSWORTH VA HOSP.
Los Angeles
LONG BEACH NAVAL HOSP.
Long Beach
To San Diego Naval Hospital
APPROXIMATE DISTANCES BETWEEN:
Port Hueneme Naval and Long Beach Naval - 85 miles
Port Hueneme Naval and San Diego Naval - 190 miles

CASE STUDY 8

UNANSWERED QUESTIONS PRECLUDE VA FROM SHARING WITH NAVY

VA was willing and able to provide some medical services to Navy beneficiaries under a formal sharing agreement, but doubted that any sharing would occur without clarifying guidance from VA and Navy headquarters.

Because the Naval Hospital, Port Hueneme, California, was not staffed to provide the full range of needed medical services, the possibilities of obtaining specialized services from other Federal facilities in the area were explored. Navy contacted VA Medical District No. 26 officials in the Los Angeles area and asked whether Navy patients could be referred for sophisticated specialties like neurology; urology; ear, nose, and throat; and ophthalmology. Navy believed these services were available at two large VA hospitals--Sepulveda and Wadsworth--in the general area.

Port Hueneme usually obtained these services at the Long Beach Naval Hospital for active duty patients and under CHAMPUS for retirees and dependents, but problems had developed. Long Beach had its own workload limitations and traveltime and distance often precluded quick medical disposition, according to Port Hueneme officials. Also, CHAMPUS patients were finding it increasingly difficult to locate civilian physicians willing to provide service at the CHAMPUS authorized fee schedule. Thus, Navy wanted to use VA as a referral source for all beneficiary categories, even though it believed VA's law prohibited retirees and dependents from being treated.

VA responded to Navy's request by stating that Navy's beneficiaries could probably be treated routinely at the Sepulveda and Wadsworth VA Hospitals if (1) a sharing agreement (under 38 U.S.C. 5053) could be established and (2) the care would be furnished on a space available basis to be determined by the affected VA hospitals.

VA also identified several problems which it felt would have to be resolved before any sharing could begin.

1. VA would need the formal sharing agreement under 38 U.S.C. 5053 for reimbursements to revert to providing hospitals. A VA official said Navy did not know whether it could participate in a sharing agreement; Navy appeared to want payment at

standard interagency rates with fund transfers between Navy and VA headquarters. VA, however, did not want interagency fund transfers because reimbursements would be retained at headquarters. Consequently, no incentive whatsoever existed for VA to do any work for others without a sharing agreement. At least with a sharing agreement, the VA providing hospitals would have a chance at being reimbursed, if VA's Central Office allowed it.

2. According to a VA official, VA's Central Office wanted Navy to answer the following questions before any type of agreement to treat Navy beneficiaries would be approved: Would VA or Navy fill prescriptions written by a VA physician? Would VA or Navy furnish eyeglasses for Navy referrals? Would recommended hospitalization resulting from a Navy outpatient referral be provided by VA or Navy? These and other services which might result from Navy outpatient referrals might cost VA a lot more money than the original care.

3. Active duty military and persons treated under sharing agreements have the lowest priority for VA care. Therefore, VA believed that a Navy patient could get "bumped" by a higher priority VA patient even while the Navy beneficiary was at the hospital waiting for an appointment. As a result, VA felt that few, if any, Navy beneficiaries would even be seen at a VA hospital under current conditions.

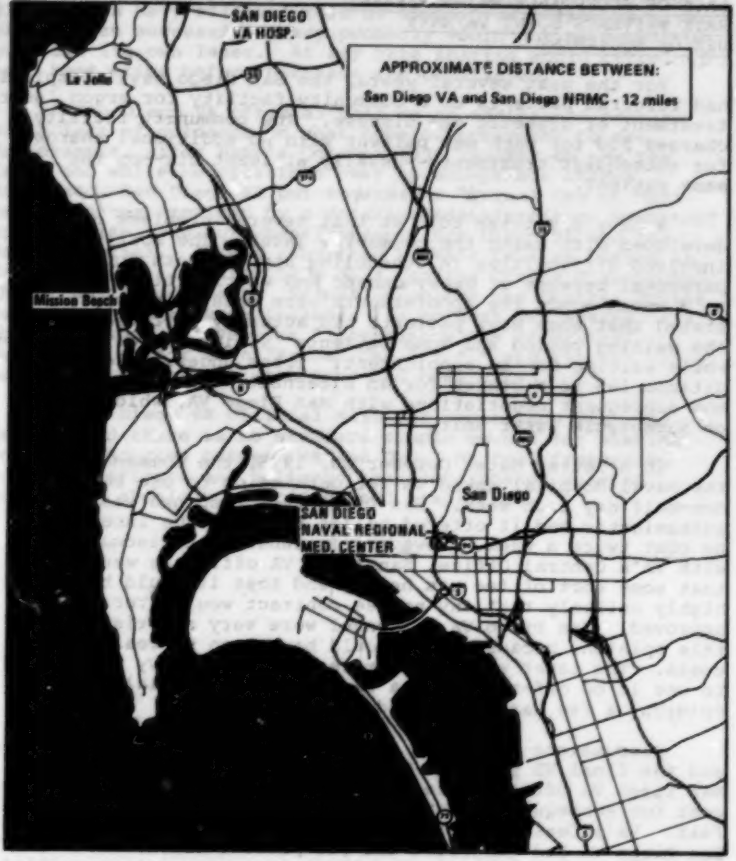
At Port Hueneme we were told Navy had also identified several obstacles to sharing with VA, including reimbursement questions and VA's apparent restrictions on Navy beneficiaries.

Port Hueneme officials told us that Navy's interagency reimbursement system requires billing and collecting at headquarters level using interagency rates. Port Hueneme would not become involved with billing or collecting, and evidently no mechanism exists for agencies to reimburse each other locally. The officials believed this would present a problem if VA wanted reimbursement any other way besides the headquarters fund transfer. When we visited Port Hueneme, VA and Navy had not discussed payment mechanisms but VA had mentioned needing a sharing agreement using full costs. Navy officials were also uncertain whether they could enter into a VA sharing agreement.

We asked whether Port Hueneme could reimburse VA from hospital supplemental funds used to pay community physicians and hospitals for services beyond Navy's capabilities. The officials did not know the answer and had no experience on which to draw. They subsequently contacted Navy's Bureau of Medicine and Surgery in Washington, D.C., and were told no procedures existed for Navy to pay VA from supplemental funds.

Port Hueneme officials were also concerned about VA's regulations restricting Navy patients to the lowest priority. They believed all Navy patients should be treated equally with other Federal beneficiaries going to VA hospitals. Moreover, they felt that priorities among Federal agencies should be structured to provide for maximum sharing regardless of what type Federal beneficiary was involved.

SELECTED FEDERAL HOSPITALS IN THE SAN DIEGO, CALIFORNIA, AREA


SAN DIEGO
VA HOSP.
APPROXIMATE DISTANCE BETWEEN:
San Diego VA and San Diego NRMC - 12 miles
La Jolla
Mission Beach
San Diego
SAN DIEGO
NAVAL REGIONAL
MED. CENTER

CASE STUDY 9

LACK OF ACCEPTABLE REIMBURSEMENT RATE PREVENTS JOINT VA/NAVY USE OF EQUIPMENT

For the past several years, the San Diego Naval Hospital had referred patients to a community facility for argon laser treatment of diabetic eye disease. The community facility charged $50 for each new patient with no additional charge for subsequent treatments--usually at least six--on the same patient.

A Navy physician told us that several problems had developed with using the community laser. The most serious involved difficulties in scheduling appointments for Navy personnel because of heavy demand and waiting time--as long as 3 weeks--once the appointments were made. The physician stated that some Navy patients had actually suffered during the waiting period and some patients' vision had deteriorated while waiting for an appointment. These undesirable conditions led to a search for an alternate means of treatment, and subsequent negotiations with San Diego VA, which had an acceptable laser unit.

In a letter dated October 30, 1975, the Commander of the Naval Hospital asked VA for permission to use the laser one-half day each week. San Diego VA's response was enthusiastic and it offered to let Navy use the laser at no cost twice a week. However, in subsequent discussions with VA's Central Office, San Diego VA officials were told that some sort of fee was needed and that it would be highly unlikely that any no-fee contract would ever be approved. San Diego VA personnel were very surprised by this opinion, because there would have been no real local costs. The laser was used for research, and Navy was going to use it on off-time. In a San Diego VA official's opinion, a fee was not needed.

Discussions over what fee to charge took several months, and the final VA proposal was unacceptable to the Navy. San Diego VA officials felt that $25 for each patient without cost for subsequent treatments on the same patient would be fair. VA's Central Office, however, stated that although San Diego VA had justified the $25 patient fee, a more appropriate rate would be the $39 interagency rate specified for an outpatient visit. The $39 was to be charged for each treatment, while Navy's price in the community was an initial $50 charge with no subsequent charges for additional treatment.

According to a Navy official, the lengthy negotiations were very frustrating. Because an equitable charge could not be established, Navy ordered its own laser at a cost of $30,000. A Navy official told us that if negotiations with VA had been successful, Navy probably would not have had to purchase its own laser. At any rate sharing would certainly have been tried before purchase was considered.

A San Diego VA official told us an additional problem was a lack of guidance on what type of agreement to use. For example, after Navy's October 1975 request to use the laser and while negotiations over an acceptable charge continued, San Diego VA put together a "Mutual Use of Medical Resources Provided by a Veterans Administration Hospital" contract (sharing agreement) between San Diego VA and the Naval Hospital. It was submitted to VA's Central Office in January 1976. In March 1976 VA's Central Office disapproved the proposed agreement. Several problems the Central Office had with the agreement included (1) no cost was stated, (2) the title should have been "Interagency Use of Medical Resources" rather than "Mutual Use * * *," and (3) the wrong authority to contract with Navy had been cited.

A San Diego VA official said the experience with the Navy showed there is no standard simple method for sharing medical resources between VA and DOD. He felt frustrated by the experience and believed that interagency sharing procedures should be clarified and simplified.

CASE STUDY 10

REIMBURSEMENT PROBLEMS HAMPER VA AND NAVY SHARING A CATHETERIZATION LABORATORY

The VA and Naval Hospitals in San Diego attempted to share VA's cardiac catheterization laboratory but met with limited success. Several problems emerged, including complicated and unclear interagency sharing authorities, reimbursement questions, and lack of incentives to share.

Physicians at the San Diego Naval Hospital needed an alternative source of providing cardiac catheterizations to Navy beneficiaries, and pursued negotiations with San Diego VA, which had an acceptable laboratory. Navy estimated about 700 patients would be catheterized in its laboratory during fiscal year 1976, more than the maximum a single laboratory could handle in a year. On the other hand, VA's laboratory was catheterizing about 150 patients a year at the time. Navy had alternatives to approaching VA--e.g., build a second catheterization laboratory, request area referral military hospitals to send their patients elsewhere, or refer retired and dependent patients to CHAMPUS--but wanted to explore the possibility of using VA's laboratory. It felt this attempt would be a test on which future sharing between Navy and VA could be based.

After several negotiation sessions between local Navy and VA officials, the Navy proposed the following guidelines for using VA's Laboratory.

--All Navy patients (active duty and retired military and their dependents, both men and women), except children, would be eligible.

--Navy would pay for disposable equipment used during catheterization procedures on Navy patients.

--Navy would provide staff cardiologist supervision for procedures performed by VA. The procedures would be performed by VA cardiology residents in training.

--The Navy's payment would pay for disposable equipment and its provision of Navy staff cardiologist supervision would constitute payment to VA, with no direct transfer of funds.

Navy felt that sharing this service offered advantages to both parties. Shifting about 200 Navy patients a year to VA would ease the demands on Navy's overburdened laboratory. VA would benefit by increased workload, which would (1) enhance the resident training program, and (2) further justify the laboratory's existence.

Problems developed, however, when San Diego VA began trying to figure out exactly how to set up a sharing agreement. Since VA knew that some type of charge would be necessary to gain VA Central Office approval of the agreement, it finally agreed to furnish the supplies and charge Navy VA's interagency rate ($102 per inpatient day during fiscal year 1976). This rate was the primary cause of two major obstacles encountered by VA and Navy in their efforts to share. These obstacles were:

1. Lack of incentive to share. San Diego VA felt that it had no incentive to share facilities and equipment with Navy (or any other Federal facilities) since the catheterization payments ($102 a day for 2 days, or $204) would not cover the costs of supplies and personnel necessary to support Navy catheterizations. Further, at one time Navy wanted VA to consider Navy patients as its own and receive a funding increase through the appropriations process because of a higher workload, rather than be reimbursed by Navy. San Diego VA felt that the interagency reimbursement received from the Navy would at least cover some costs, _if_ the funds collected were returned to San Diego VA. The reimbursement process was not clearly understood and led to the following closely related obstacle.

2. No local reimbursement. As San Diego VA understood the reimbursement process, the Navy reimbursements at interagency rates would flow to VA's Central Office and be credited to an appropriation account. It was unclear whether the funds would then be returned to the local VA hospital. The San Diego VA Hospital Director tried to obtain clarification on the reimbursement mechanism from VA's Central Office. He was told it "didn't know" whether the Navy funds could be returned to San Diego VA or would be kept in the VA general appropriation account. One San Diego VA official commented that VA's Central Office might prefer to keep the reimbursements to assure that "double dipping" did not

occur; that is, a service or facility already supported by appropriated funds would not be supplemented by reimbursement from another Federal agency. San Diego VA officials contended, however, that the appropriations for the cardiac catheterization laboratory would not be nearly adequate to cover expenses incurred by an influx of Navy patients. Consequently, the officials believed they would have to be reimbursed locally or they would not routinely share their capabilities.

Over a period of several months, San Diego VA tried different agreements and authorities to develop a mutually acceptable sharing arrangement. For example, VA's Central Office approved an interagency agreement, under the Economy Act (31 U.S.C. 686), but told San Diego VA there was no known way Navy funds received for services could be reimbursed to the providing hospital. However, VA's Central Office advised that funds could be reimbursed to the providing hospital if VA had an approved sharing agreement under 38 U.S.C. 5053, the sharing law. With this in mind, San Diego VA drafted a sharing agreement in place of the interagency agreement and presented it to Navy. VA's price increased to $300 for each catheterization to recover estimated full costs.

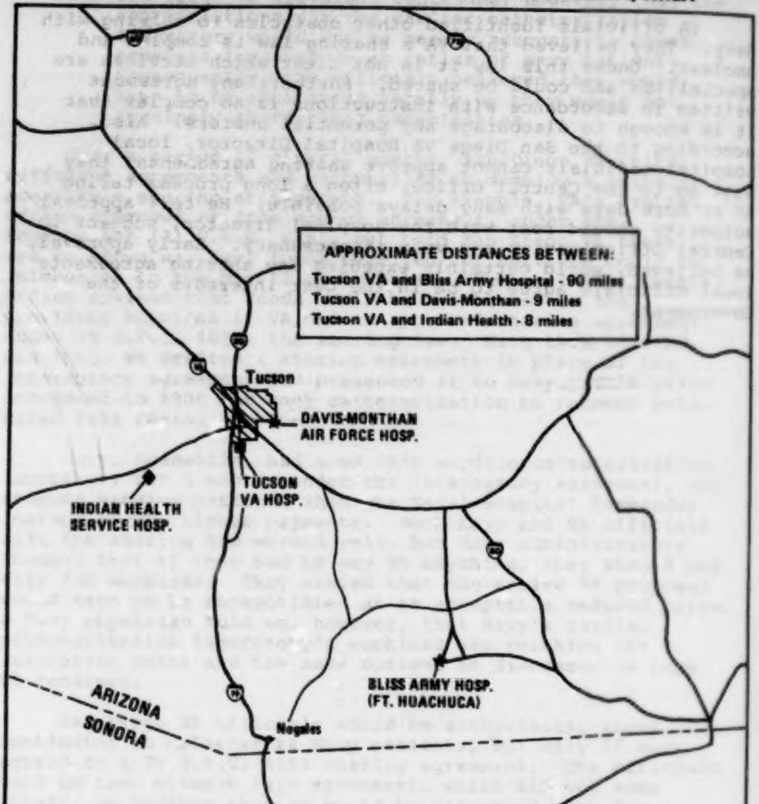
Navy, meanwhile, had used VA's cardiac catheterization laboratory for 5 months under the interagency agreement, but stopped sending patients when the Naval Hospital Commander learned of the higher payments. Both Navy and VA officials felt the sharing had worked well, but Navy administrators thought that if they had to pay VA anything, they should pay only for supplies. They stated that the entire VA proposal would have to be renegotiated at an acceptable reduced price. A Navy physician told us, however, that Navy's cardiac catheterization laboratory's workload was reaching the saturation point and the same options as discussed on page 95 remained.

San Diego VA officials would be enthusiastic about continuing to catheterize Navy patients, but only if Navy agreed to a 38 U.S.C. 5053 sharing agreement. The officials told us that without this agreement, which did not seem likely, no further sharing would be attempted with Navy.

We were also told that several other services were being considered for sharing, including radiation therapy at the Naval Hospital and cardiac surgery at VA. We later found that San Diego VA had requested a radiation therapy unit at a cost of about $895,000 for construction and equipment, so at least one other sharing opportunity has probably been lost.

VA officials identified other obstacles to sharing with Navy. They believed that VA's sharing law is complex and unclear. Under this law it is not clear which services are specialized and could be shared. Further, any agreement written in accordance with instructions is so complex that it is enough to discourage any potential sharers. Also, according to the San Diege VA Hospital Director, local hospital officials cannot approve sharing agreements; they must go to the Central Office, often a long process taking 60 or more days with many delays possible. He felt approval authority should rest with the hospital director, subject to Central Office review and veto if necessary. Early approval, he believed, would certainly expedite any sharing agreements local officials agree to be in the best interests of the Government.

SELECTED FEDERAL HOSPITALS IN THE TUCSON, ARIZONA, AREA


APPROXIMATE DISTANCES BETWEEN:
Tucson VA and Bliss Army Hospital - 90 miles
Tucson VA and Davis-Monthan - 9 miles
Tucson VA and Indian Health - 8 miles
Tucson
DAVIS-MONTHAN AIR FORCE HOSP.
TUCSON VA HOSP.
INDIAN HEALTH SERVICE HOSP.
BLISS ARMY HOSP. (FT. HUACHUCA)
ARIZONA
SONORA
Nogales

CASE STUDY 11

REIMBURSEMENT PROBLEMS CURTAIL SHARING BETWEEN VA AND OTHER FEDERAL FACILITIES

In fiscal year 1976 Tucson VA provided health services, including nuclear medical scans and electroencephalograms to military beneficiaries (active duty and retired members and their dependents), as follows:

- --Davis-Monthan Air Force Hospital beneficiaries. Most services were performed on an outpatient basis, although a few individuals were treated on an emergency inpatient basis. During the year Tucson VA billed Davis-Monthan about $20,000 for services.
- --Bliss Army Hospital beneficiaries. These patients were mostly military dependents, although some active duty and retired members were also treated. A VA hospital official told us no Army beneficiaries had been treated on an inpatient basis. Tucson VA billed Bliss about $6,000 for the services provided during fiscal year 1976.

If the military hospitals had contracted with local civilian hospitals for the services provided by VA, the costs would have been substantially greater than the $26,000 paid to VA.

In addition, Tucson VA provided a wide variety of both inpatient and outpatient services to Indian Health Service beneficiaries and billed the Indian Health Service about $126,000 for these services.

Tucson VA provided these services under the broad authority in the Economy Act (31 U.S.C. 686). This authority does not require formal sharing agreements between Federal agencies. Under this authority interagency reimbursements are based upon the actual cost of services. (However, VA's annual appropriations acts require reimbursement at rates established by VA to reflect the average actual costs of services provided to other agencies. These rates are approved by the Office of Management and Budget.)

Reimbursement difficulties

Until October 1976 Tucson VA received reimbursement from VA's Central Office for the services provided to the Air

Force, Army, and Indian Health Service. Tucson VA billed the other agencies at its interagency rates ($102 per inpatient day and $33 for an outpatient visit during fiscal year 1976). Tucson VA was depositing the payments in a VA Central Office receivable account. Then, during each fiscal year quarter, Tucson VA requested reimbursement from VA's Central Office for the amounts deposited. The requests were honored by VA's Central Office in the form of increased obligational authority to Tucson VA.

However, the reimbursement procedure was apparently not in accordance with VA Central Office's internal policy. Central Office officials said VA policy requires depositing reimbursements in a Central Office-controlled Treasury account with no increased obligational authority being granted to the providing VA hospital.

Nevertheless, Tucson VA received about $152,000 of increased obligational authority in fiscal year 1976 because the Central Office Budget Staff believed that the services to the other agencies had been rendered under formal sharing agreements authorized by VA's sharing law (38 U.S.C. 5053) instead of the interagency arrangements authorized by 31 U.S.C. 686. Formal sharing agreements must involve specialized medical resources, and reimbursement must cover full costs. Also, to encourage sharing, reimbursements revert to the providing VA hospital.

During the fall of 1976, the Central Office Budget Staff reviewed Tucson VA's quarterly report which requested reimbursement for the services rendered and discovered the discrepancies in the legal authority under which Tucson VA was providing services to other Federal beneficiaries. Consequently, Tucson VA's Fiscal Service officials were informed that, effective October 1, 1976, no more reimbursements to the hospital would be allowed for services to Air Force and Army beneficiaries. However, reimbursements were to continue for the services to Indian Health Service beneficiaries. No explanation was provided to local hospital officials for the inconsistency.

We were told in March 1977 that Tucson VA would continue to provide services to the Air Force and Army--even though reimbursements from VA's Central Office to the hospital for these services had stopped--at least until April 1977 when Tucson VA's budget was to be reviewed. However, we were informed in May 1977 that Tucson VA would no longer provide services to the military beneficiaries because of increased workload and budgetary considerations.

The Central Office Budget Staff Director believes that it is incorrect to consider other agencies' reimbursements to VA hospitals as not reverting to the local hospitals. The Director told us that the total reimbursements received are used to offset the total budgetary requests made by VA to the Congress for medical care. Consequently, the total reimbursements from all sources--estimated in fiscal year 1977 for budget purposes to be $33 million--are redistributed to all VA hospitals. However, the VA budget system does not provide the means to determine how much reimbursement goes to each individual hospital.

Also the Director said the reimbursements for services to Indian beneficiaries had been and would continue to revert to Tucson VA. This action was considered necessary because of the hardship nonreimbursement would cause if Tucson VA could not count on having these substantial revenues to offset expenses of providing services to the Indians.

Although services to military beneficiaries by Tucson VA amounted to only about $26,000 during fiscal year 1976, Tuscon VA feels this is still worthy of consideration for full reimbursement to Tuscon VA. They believe that, at a minimum, some sort of reimbursement should be received. Services could be provided using VA's interagency rates if Tucson VA received the funds back.

However, Tucson VA would rather be paid full costs similar to those received under their formal sharing agreement with the Arizona Medical Center University Hospital. Under that agreement Tucson provided about $340,000 worth of services to the medical center in fiscal year 1976. Any full cost provision--a requirement for a formal sharing agreement--with the military is considered unlikely, however, since the military usually wants to pay only the interagency rates.

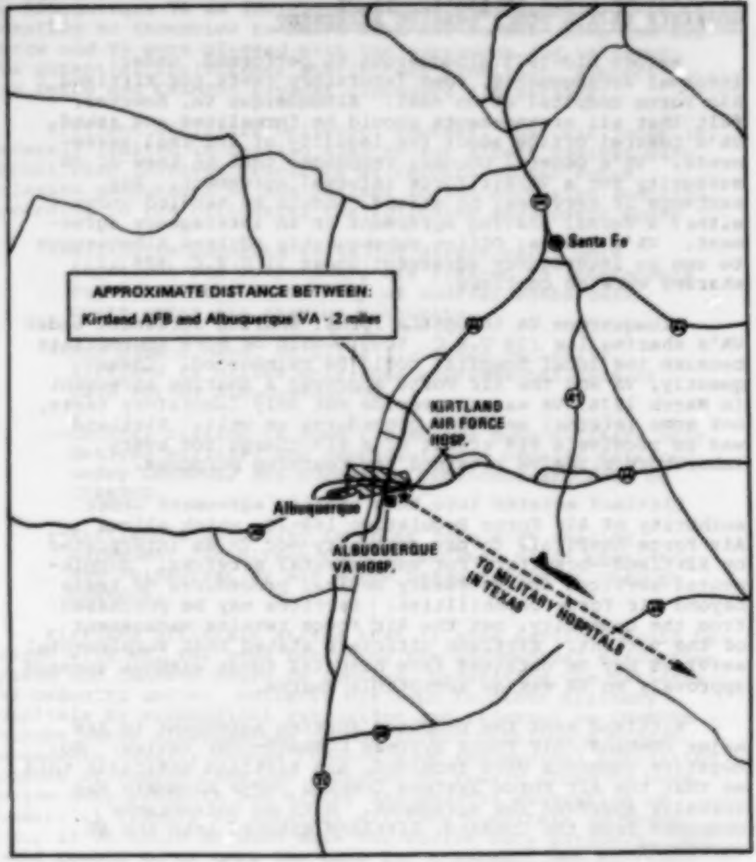
Additional obstacles impede successful sharing

Tucson VA has tried unsuccessfully several times to enter into formal sharing agreements through which medical services could be provided to military beneficiaries. In the latest of these attempts, Tucson VA officials met with Davis-Monthan Air Force Hospital representatives in May 1974 and proposed a sharing agreement to formalize, under 38 U.S.C. 5053, VA's sharing of specialized medical services with Davis-Monthan. Under the proposed agreement, VA's charges were to be established using full costs of the specialized services, instead of the OMB-approved interagency rates. Davis-Monthan never formally responded to the proposal, but verbally told VA it could not pay anything but the interagency rates. In view of Air Force's refusal to pay full costs under a sharing agreement, Tucson VA resorted to the Economy Act's authority and provided services to Air Force at the interagency rates.

Tucson VA felt that Air Force--and other Federal--beneficiaries could be served without any reduction of service to eligible veterans. It also believed that for some specialized services--particularly nuclear medicine--all the staff and equipment needed to treat veterans were available. Furthermore, with no increases in staff or equipment, the Air Force beneficiaries could be treated at a benefit to both Air Force and VA. The Air Force patients would receive excellent services within the Federal community, and VA would be benefited by increased use of its resources. Also, and perhaps most importantly, professional people from Tucson VA and Davis-Monthan would be working together to provide better care for both veterans and other Federal beneficiaries.

The sharing efforts of Tucson area Federal officials represent an important step toward increased sharing of Federal medical capability. However, these efforts also illustrate the numerous obstacles which must be overcome before widespread sharing will occur.

SELECTED FEDERAL HOSPITALS IN THE ALBUQUERQUE, NEW MEXICO, AREA


Santa Fe
APPROXIMATE DISTANCE BETWEEN:
Kirtland AFB and Albuquerque VA - 2 miles
KIRTLAND AIR FORCE HOSP.
Albuquerque
ALBUQUERQUE VA HOSP.
TO MILITARY HOSPITALS IN TEXAS

CASE STUDY 12

REGULATIONS LIMIT INCREASED USE OF WORKABLE VA/AIR FORCE SHARING AGREEMENT

Before mid-1975 Albuquerque VA performed, under informal arrangements, some laboratory tests for Kirtland Air Force Hospital at no cost. Albuquerque VA, however, felt that all arrangements should be formalized and asked VA's Central Office about the legality of informal agreements. VA's General Counsel responded that he knew of no authority for a VA/Air Force informal agreement. Any exchange of services, he stated, should be handled under either a formal sharing agreement or an interagency agreement. VA's Central Office subsequently advised Albuquerque to use an interagency agreement under 31 U.S.C. 686 if sharing were to continue.

Albuquerque VA thought a formal sharing agreement under VA's sharing law (38 U.S.C. 5053) would be more appropriate because the local hospital could be reimbursed. Consequently, VA and the Air Force approved a sharing agreement in March 1976; VA was to provide not only laboratory tests, but some internal medicine procedures as well. Kirtland was to receive a $14 credit of a $15 charge for every laboratory slide VA retained for teaching purposes.

Kirtland entered into VA's sharing agreement under authority of Air Force Regulation 168-10, which allows Air Force hospitals to pay community--or VA as interpreted by Kirtland--hospitals for supplemental services. Supplemental services are necessary medical procedures or tests beyond Air Force capabilities. Services may be purchased from the community, but the Air Force retains management of the patient. Kirtland officials stated that supplemental services may be obtained from hospital funds without command approval, so VA was an acceptable source.

Kirtland sent the proposed sharing agreement to its major command--Air Force Systems Command--for review. No negative comments were received, and Kirtland officials told us that the Air Force Systems Command Judge Advocate had verbally approved the agreement. With no unfavorable comments from the Command, Kirtland entered into the VA agreement.

According to VA and Air Force officials, the agreement worked well for over a year and was to be expanded. VA did not limit the categories of Air Force patients covered.

Active duty military, retired military, and dependents were all treated. Funds collected from Kirtland--about $8,400--were forwarded to VA's Central Office and later returned to Albuquerque VA as increased obligational authority, creating an incentive to share with Air Force. Both the Air Force and VA were pleased with the agreement and believed the potential for further sharing was excellent, subject to Air Force and CHAMPUS payment procedure limitations.

Kirtland officials believed, however, that Air Force is severely limited in dealing with VA for direct patient care. Direct care involves transfers or referrals; Air Force releases management of the patient to the accepting hospital. According to the officials, the following procedures apply:

--Air Force payments to VA for direct care, both inpatient and outpatient, are limited to interagency reimbursement rates. VA, of course, wants full costs under its sharing authority.

--For direct care, VA bills Air Force centrally. Kirtland is billed only when supplemental care is paid for by Albuquerque VA.

--Central billing is done for active duty military only. Retired military and dependents are usually referred under CHAMPUS, and community providers are paid by CHAMPUS.

--Kirtland's authority to enter into a VA sharing agreement for direct care is unclear since providers are reimbursed by Air Force headquarters or through CHAMPUS.

Kirtland officials stated that if more services could be shared with VA, the need for using the aeromedical evacuation system and CHAMPUS would be reduced, benefiting the patients and reducing costs. Patients are sent to other military hospitals by aeromedical evacuation and referred to CHAMPUS because these alternatives do not affect Kirtland's budget. Dependents usually choose CHAMPUS over aeromedical evacuation because of family ties and a desire to remain close to home. Active duty patients use either aeromedical evacuation or commercial flights to referral military hospitals in Texas. Also, if VA could be used more for active duty patients, they could remain on or near the base for treatment and Kirtland medical officials would know test results faster.

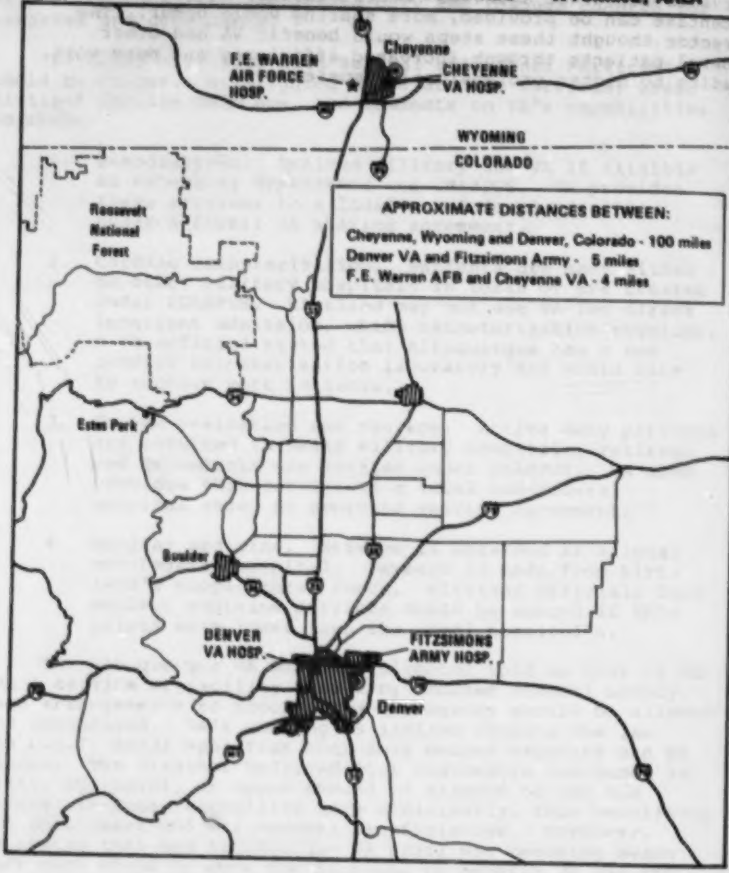
Kirtland officials feel that regulations must be revised to allow VA to provide direct care to Air Force patients, including dependents. Also provisions would have to be made for Kirtland to pay locally the charges which are now being paid at headquarters for active duty and through CHAMPUS for retirees and dependents.

Kirtland officials said several additional services could be shared. Highlighted below are the services, where Kirtland obtains them now, and comments on VA's capabilities to share.

1. Hemodialysis. Retired military use VA if eligible as veterans; dependents use CHAMPUS. VA provides these services to a local non-Federal hospital under a formal VA sharing agreement.
2. Cardiac catheterization. Patients are sent either to other military hospitals in Texas or are treated under CHAMPUS. Kirtland may not use VA for direct inpatient admission, which catheterization requires. A VA official stated that Albuquerque has a new cardiac catheterization laboratory and would like to receive more patients.
3. Speech evaluation and therapy. Active duty patients are referred to Texas military hospitals; retirees and dependents are treated under CHAMPUS. VA also provides this service to a local non-Federal hospital under an approved sharing agreement.
4. Nuclear medicine. Service is obtained at a local non-Federal hospital. Payment is made from Kirtland's supplemental funds. Kirtland officials feel nuclear medicine services could be shared if VA's prices were lower than the local hospital's.

The Albuquerque VA Hospital Director told us that if VA has a service or facility needed by another Federal agency, then arrangements to accommodate the agency should be allowed and encouraged. VA's sharing is limited because the law (38 U.S.C. 5053) specifies that only unused capacity can be shared. The Director believed that reasonable increases in staff, equipment, or space should be allowed to use the Federal in-house capability more efficiently, thus benefiting the Government and all Federal beneficiaries. Moreover, he stated that the Albuquerque VA staff was becoming aware that work could be done for Kirtland to benefit VA and the Air Force. In addition, Albuquerque VA management will try to provide an incentive to the medical service chiefs and their personnel. This will be done by looking favorably on requests for staff to be paid for from sharing agreement proceeds, if the workload dictates. Usually service chiefs and their personnel are reluctant to perform additional services for other agencies' beneficiaries, but if an incentive can be provided, more sharing would occur. The Director thought these steps would benefit VA and other Federal patients through increased efficiency and more work, leading to higher professional competence.

SELECTED FEDERAL HOSPITALS IN THE COLORADO — WYOMING, AREA


Cheyenne
F.E. WARREN AIR FORCE HOSP.
CHEYENNE VA HOSP.
WYOMING
COLORADO
Roosevelt National Forest
Estes Park
Boulder
DENVER VA HOSP.
FITZSIMONS ARMY HOSP.
Denver

APPROXIMATE DISTANCES BETWEEN:

Cheyenne, Wyoming and Denver, Colorado - 100 miles
Denver VA and Fitzsimons Army - 5 miles
F.E. Warren AFB and Cheyenne VA - 4 miles

CASE STUDY 13

ADMINISTRATIVE INACTION AND ATTITUDINAL BARRIERS HAMPER SHARING BETWEEN VA AND AIR FORCE

In late 1973 F.E. Warren Air Force Hospital asked Cheyenne VA to allow it to use VA's radiology equipment for angiographic procedures on Air Force patients using Air Force staff and supplies. Warren's parent command, the Strategic Air Command, gave permission for such an arrangement.

In a letter dated November 23, 1973, Cheyenne VA sought VA Central Office approval for the arrangement without entering into a formal sharing agreement. The letter, signed by the Cheyenne VA Hospital Director, stated:

> "It seems logical that two Federal agencies should be able to work together in the spirit of cooperation and yet, I am aware that there may be some legal implications before we proceed further."

VA's Central Office notified Cheyenne that an exchange of service agreement would have to be completed and approved by the Central Office before the sharing could take place. Subsequently, an agreement to provide the service at no charge was prepared, signed by the Warren Hospital Commander and forwarded to the Central Office on January 28, 1974.

Although Cheyenne VA officials said they had made several inquiries about the status of the request, VA's Central Office took no action on the request. Cheyenne VA files show that in a telephone conversation between VA's Central Office and the Cheyenne VA Hospital Director on October 2, 1974, about a year after the initial request, it was agreed that the proposed contract was to be dropped for the time being. Cheyenne VA officials said by late 1974 the Warren radiologist making the request had left Warren and there was no longer any push from Warren to act. They said they were unaware of why VA's Central Office had not acted on the request.

Other than this attempt at official sharing, no further sharing had taken place between Warren and Cheyenne VA except for dental X-ray services. Cheyenne VA had provided dental X-ray service to Warren patients several times during the last few years. The X-ray, a large size not available at Warren, was provided on an informal, nonreimbursable basis. Warren and VA dental personnel arranged for the

X-rays. Cheyenne VA dental personnel asked other VA officials about the propriety of providing the service and were told that they should not provide the service unless Warren paid an outpatient fee of $39 for each visit.

Warren refers patients needing care beyond its capabilities as follows: (1) aeromedical evacuation to distant military medical facilities, (2) transportation to local hospitals, clinics, and physicians, and (3) transportation to Fitzsimons Army Medical Center in Denver--about 100 miles away.

According to Cheyenne VA medical personnel, some support could be provided Warren in orthopedic care, pulmonary medicine, gastroenterology, physical therapy, and surgical and dental consultations. VA personnel told us that in some cases, only limited support could be offered. However, these services could serve as initial opportunities for sharing between the facilities. This would be contingent, however, on eliminating some regulatory, budgetary reimbursement, and attitudinal factors which, according to Cheyenne and Warren officials, have impeded effective sharing between the facilities.

Legal and regulatory

According to Warren's Commander, Air Force regulations do not authorize providing routine medical care to many veterans eligible for care in VA hospitals. The Commander believed the regulations should be revised to allow Air Force hospitals to treat all veteran patients. Further, he said the absence of necessary guidance on sharing, particularly on sharing medical specialists, has served as a barrier to effective sharing with VA. The Commander believed sharing between DOD and VA can be improved by informing both parties of the benefits of sharing and by revising VA and DOD regulations to optimize sharing activities. Cheyenne VA officials related similar regulatory barriers. According to the Director, Cheyenne VA, regulations do not allow VA to provide routine medical services to uniformed services dependents. The Director said regulations governing sharing agreements stipulate that a VA hospital can enter into an agreement only when "excess capacity" exists within the hospital, i.e., when it has underused staff, space, or equipment. He explained it is sometimes difficult to properly define "excess capacity."

The Director, Cheyenne VA, was unsure whether Cheyenne VA could legally enter into formal sharing agreements (38 U.S.C. 5053) with other Federal agencies or whether such an agreement was necessary for Cheyenne VA to provide care to Warren personnel. The Director believes a change in VA's mission is required which would allow VA hospitals to provide an increased level of care to active duty and retired service personnel and their dependents. Also current legislation governing the provision of medical care to dependents of service members by VA hospitals would require modification allowing VA hospitals to care for such patients.

Budgetary

Funding also hampers sharing. According to Cheyenne VA officials, Cheyenne VA was funded to provide 12,750 outpatients visits during fiscal year 1977. Recent Cheyenne VA projections indicate Cheyenne VA expects to receive requests for about 16,000 outpatient visits during the same period. In response to the rising demand for outpatient care, VA's Central Office established, by directive, priorities governing treatment provided outpatients. Under the directive beneficiaries from other Federal agencies, active or retired military personnel, and persons treated under sharing agreements are assigned the lowest priority for outpatient services. The Director said the funded level of 12,750 outpatient visits will permit Cheyenne VA to treat only higher priority patients, and since Warren's patients would fall into the lowest priority, Cheyenne VA could not provide care to these patients.

Reimbursement rates

Cheyenne VA's charge for outpatient service hampers sharing in a manner similar to that in which funding hampers sharing. Warren administrative personnel said that on several occasions they had contacted Cheyenne VA regarding the possibility of providing Warren patients with outpatient services. When the care required was available from Cheyenne VA, the charge exceeded the cost of obtaining the same care from Cheyenne community providers.

A case involving physical therapy required by an active duty Air Force member illustrates the problem. Warren contacted Cheyenne VA regarding the availability of certain physical therapy treatments and were advised that Cheyenne VA could provide the treatment at the rate of $39 for each outpatient visit. Warren also contacted two local community hospitals about the availability of the treatments and were advised that each hospital could provide the treatments. The charges at the community hospitals totaled about $4 for each visit after an initial one-time phsycian's referral charge of $10 to $15.

Warren expressed the belief that Cheyenne VA and Warren should share resources in a cooperative manner. However, because Cheyenne VA charges often exceed those for care at community resources, Warren has elected to use the community facilities.

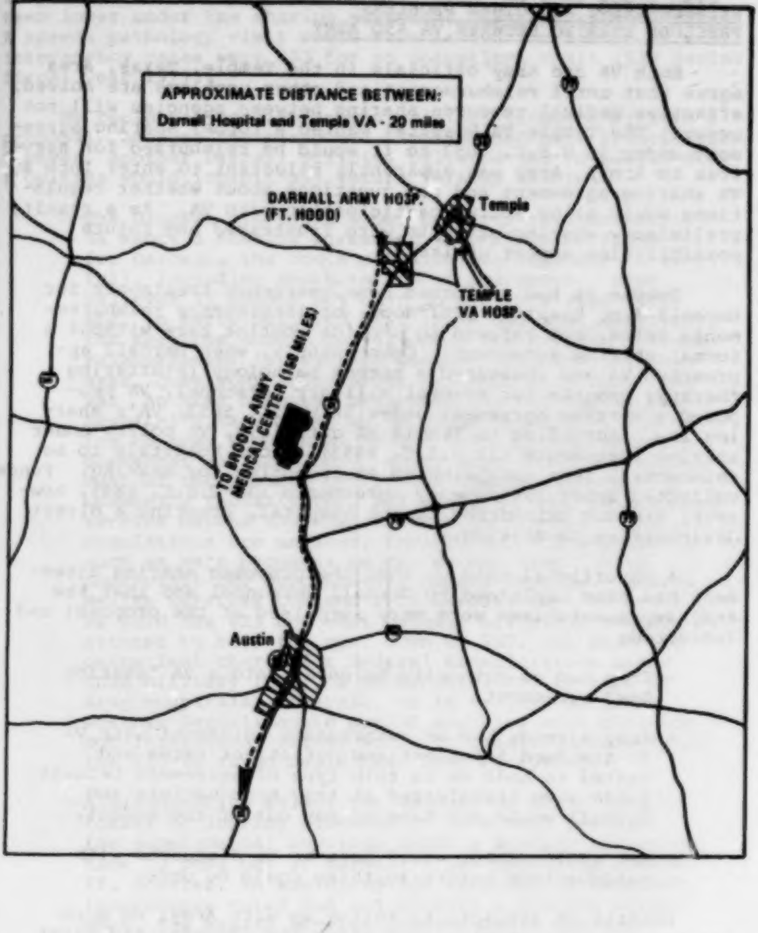
Attitudes

Attitudes of Warren and Cheyenne VA officials may hinder sharing between the two facilities. For example, the Warren Commander told us his predecessor had advised him that past attempts to initiate sharing agreements with Cheyenne VA had been unsuccessful and further efforts would meet with a similar result. He had not approached Cheyenne VA with any sharing proposals because of these unsuccessful efforts. He believed an increased willingness to cooperate is required on VA's part before sharing can occur.

The Director, Cheyenne VA, said the reason no formal sharing agreements exist between his facility and Warren is because of the limited cooperation between the two facilities in the past. Cooperation to date has been on a case-by-case basis. The topic of using sharing agreements never arose except in the one attempt to share radiology services, which failed.

Further, Cheyenne VA officials told us the reasons Warren had not been considered as a surgical alternative during a recent closing of Cheyenne VA surgical suites was because of uncertainty over Warren's surgical capability. The officials said Cheyenne VA's longstanding relationship with and reliance on the Denver VA Hospital also were strong factors in the decision to send their surgical patients to Denver rather than contacting Warren.

SELECTED FEDERAL HOSPITALS IN THE TEMPLE, TEXAS, AREA


APPROXIMATE DISTANCE BETWEEN:
Darnall Hospital and Temple VA - 20 miles
DARNALL ARMY HOSP. (FT. HOOD)
Temple
TEMPLE VA HOSP.
TO BROOKE ARMY MEDICAL CENTER (150 MILES)
Austin

CASE STUDY 14

REIMBURSEMENT AND OTHER PROBLEMS PRECLUDE SHARING BETWEEN VA AND ARMY

Both VA and Army officials in the Temple, Texas, area agree that until reimbursement and other problems are solved, effective medical resource sharing between agencies will not occur. The Temple VA Hospital wanted a formal sharing agreement under 38 U.S.C. 5053 so it would be reimbursed for services to Army. Army was apparently reluctant to enter into a VA sharing agreement and had questions about whether regulations would allow active participation with VA. As a result, preliminary sharing attempts were frustrated and future possibilities appear unlikely.

Temple VA had performed some emergency treatments for Darnall Army Hospital (Ft. Hood) at interagency reimbursements rates, but refused to provide routine care without a formal sharing agreement. Consequently, when Darnall approached VA and requested a speech pathology (stuttering therapy) program for several military personnel, VA proposed a sharing agreement under 38 U.S.C. 5053, VA's sharing law. According to Temple VA officials, VA policy under sharing agreements (38 U.S.C. 5053) allows hospitals to be reimbursed, thus establishing an incentive for sharing. Funds collected under interagency agreements (31 U.S.C. 686), however, are not reimbursed to the hospital, creating a direct disincentive to sharing.

A VA official told us that the proposed sharing agreement had been explained to Darnall personnel and that the Army representatives were very surprised at the proposal and indicated:

--They had no authority to enter into a VA "sharing law" agreement.

--Army already had an interagency agreement with VA at standard inpatient and outpatient rates and wanted to hold VA to this type of agreement because funds were transferred at Army headquarters and Darnall would not have to pay out of the budget.

--The whole matter would have to be discussed with headquarters before anything could be done.

Despite VA attempts to follow up with Army, no word was received for about a year after the proposal had first been discussed. VA officials told us they had practically forgotten the sharing effort, but could not understand why Army would not accept their offer. Even the cost would have been lower under the sharing agreement than interagency rates. A speech pathology visit would have lasted for 1 hour at $25; interagency rates were $33 for an outpatient visit ($39 during fiscal year 1977).

We could not confirm Army's original problems with VA's proposal, because the personnel involved had been transferred. However, another Darnall official believed the following difficulties would inhibit any future VA/Army sharing:

--The biggest stumbling block concerns reimbursement. VA wants a sharing agreement to perform services for Darnall, the costs of which are supposed to be full, including amortization of equipment. Army believes it should not have to pay VA's full costs and, in fact, believes that if VA has the capability, the services should be performed for nothing. Since reimbursement is required between Army and VA, however, questions arise about how much Army could pay VA. An Army hospital commander may supplement his hospital's capability as he feels necessary, according to Army Regulation 40-3. This applies to supplemental services only, where Army maintains management of the patient but refers the patient to a community facility for, for example, some specialized service beyond the hospital's capabilities. The regulations are unclear, though, about instances such as VA's proposal to charge the Army $25 an hour/visit for supplemental speech therapy. Army's Health Services Command told Darnall that VA could be paid the $25 but that Darnall officials should attempt to hold the cost down to $20, the standard outpatient charge for Federal beneficiaries other than military (e.g., a VA beneficiary) treated in Army hospitals. Overall, it is really not clear whether Darnall could pay VA anything more than the DOD interagency rates, so it is questionable whether the $25 VA asked would have been acceptable.

--A disincentive exists for Darnall to enter into a formal VA sharing agreement. VA's full costs for supplemental services under a sharing agreement have to come out of Darnall's own operating budget. If, however, VA would provide services at standard interagency rates and not require a sharing agreement, the Health Service Command would pay and Darnall's budget would not be affected.

--Also, it is questionable whether military dependents may be treated at a VA hospital. Although Darnall originally wanted to send only active duty patients to VA, dependents also need speech pathology services. According to Army Regulation 40-3, chapter 15, dependents are eligible for care at Public Health Service hospitals, but VA is not mentioned. Thus, the regulation may mean that even under a sharing agreement, dependents may not be treated in VA facilities.

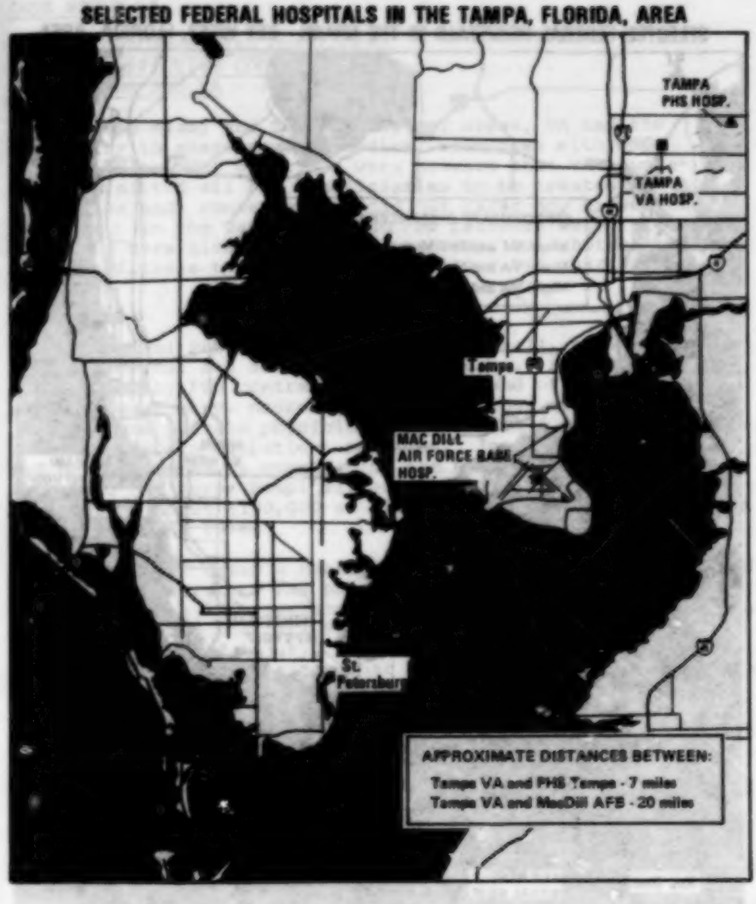
Darnall officials also told us that until these problems are solved, it does not look promising for any Army/VA agreements. The need for speech pathology will still exist, as will the need for other services. VA has or will have, for example, angiography, electromyography, and nuclear medicine.

Darnall currently obtains these services in two ways: (1) active duty patients are sent by bus 150 miles each way to Brooke Army Medical Center (not a satisfactory arrangement for optimum patient care), and (2) patients covered by CHAMPUS usually obtain nonavailability statements and receive treatment from community sources. Darnall officials believed the patients and the Government would benefit if Temple VA could provide many of the needed services. Such an ideal arrangement does not seem likely though, because of the constraints--primarily reimbursement.

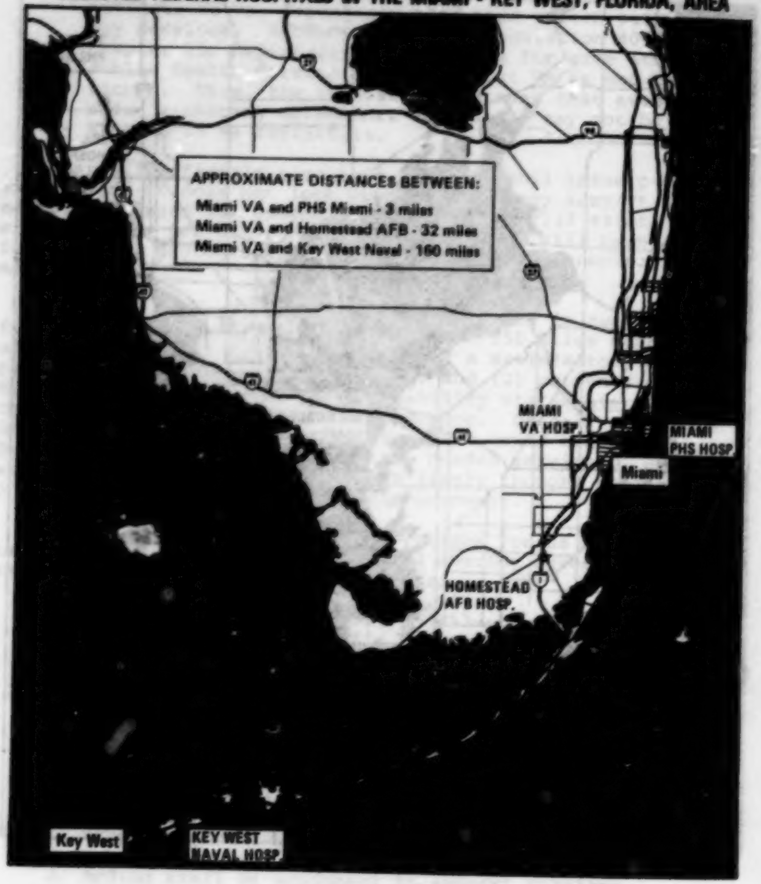
Temple VA highlighted other problems for us that they had encountered with Army's proposed sharing agreement and with sharing agreements in general.

1. VA's sharing law--38 U.S.C. 5053--is interpreted too restrictively by VA's General Counsel and therefore disallows sharing of some nonspecialized medical services which could easily be shared. The officials felt the law should allow sharing of all medical services, particularly between Federal agencies, when it is advantageous to the Government.
2. Definitive guidance does not exist for interagency agreements. This condition creates negotiating problems, which are compounded when dealing with Army personnel who are regularly rotated.
3. Adding staff or equipment to support services shared with other agencies is not allowed. Even if VA has a service needed by another agency, the sharing must be done on a excess capacity basis. VA's sharing law should allow for expansion, the officials believed.

SELECTED FEDERAL HOSPITALS IN THE TAMPA, FLORIDA, AREA


TAMPA PHS HOSP.
TAMPA VA HOSP.
Tampa
MAC DILL AIR FORCE BASE HOSP.
St. Petersburg
APPROXIMATE DISTANCES BETWEEN:
Tampa VA and PHS Tampa - 7 miles
Tampa VA and MacDill AFB - 20 miles

SELECTED FEDERAL HOSPITALS IN THE MIAMI - KEY WEST, FLORIDA, AREA


APPROXIMATE DISTANCES BETWEEN:
Miami VA and PHS Miami - 3 miles
Miami VA and Homestead AFB - 32 miles
Miami VA and Key West Naval - 160 miles
MIAMI VA HOSP.
MIAMI PHS HOSP.
Miami
HOMESTEAD AFB HOSP.
Key West
KEY WEST NAVAL HOSP.

CASE STUDY 15

SHARING OPPORTUNITIES OVERLOOKED DUE TO INEFFECTIVE COORDINATION BETWEEN PHS AND VA

In the Miami and Tampa, Florida, areas, VA had the capability to share several medical resources with PHS. However, Miami PHS officials were unaware that VA regulations permitted all PHS beneficiaries to be treated in VA facilities and, consequently, did not refer any nonveterans for care. In the Tampa area, no PHS patients were referred to VA for care although meetings had been held between PHS and VA officials to discuss opportunities for sharing.

Miami area

The Miami PHS outpatient clinic is small, providing general medical and dental outpatient care. Special clinics are staffed by PHS contract physicians, and other services, such as psychiatry, neurology, and radiology are procured locally from private physicians. During 1976 PHS purchased about $38,000 in outpatient services. Inpatient care for PHS beneficiaries is provided by the New Orleans PHS Hospital, Homestead Air Force Hospital, and local Miami hospitals. PHS Miami spent about $190,000 at civilian hospitals for inpatient services during 1976.

In several cases a nearby VA hospital could have provided the types of services PHS purchased during 1976. Generally, PHS purchased a wide variety of services, and Miami VA Hospita officials stated that all PHS patients could have been served in the spinal cord injury, cardiology, neurology, and nuclear medicine services. Savings that could have resulted had PHS used VA services are shown below.

Community services purchased	Number of Inpatients	Instances Outpatient	Cost to PHS	Cost at VA	Savings to PHS at VA
Spinal cord injury	2	-	$49,073	$26,912	$22,161
Cardiology	1	-	15,422	3,132	12,290
Neurology	-	28	1,880	1,092	788
Nuclear medicine	-	5	666	195	471
			$67,041	$31,331	$35,710

Miami PHS officials said they were unaware that VA could provide services to all PHS beneficiaries and, consequently, had referred only PHS beneficiaries who had served in the military to VA. During 1976, PHS did refer two veterans to Miami VA. However, VA hospitals were not considered as an alternative source of treatment to other types of PHS beneficiaries. Instead other civilian hospitals or the New Orleans PHS Hospital were used.

Many PHS beneficiaries are referred to hospitals by PHS contract physicians--a network of approximately 300 private physicians under contract to PHS who provide care to PHS beneficiaries in areas where PHS facilities cannot be justified. Patients seen by contract physicians are eligible to receive the same benefits as persons seen in an organized PHS facility. However, they are customarily referred to hospitals with whom PHS contracts in the absense of a specific legislative mandate to seek care from other Federal sources when available.

According to VA directives, PHS beneficiaries could be provided hospitalization, outpatient treatment, and physical examinations if duly authorized. Authorization consists of verbal approval by PHS officials followed by a memorandum. Also PHS regulations allow outpatient clinics to refer patients to VA hospitals when the urgency of the condition does not permit treatment in a PHS hospital.

However, VA regulations appear inconsistent regarding treatment of PHS and DOD dependents. VA Manual M-1, part I, section IV, precludes DOD dependents from all but emergency VA treatment, while the same section authorizes VA to treat all PHS beneficiaries, which could include DOD dependents. Miami VA officials said they would verify with VA's Central Office what is included in the terms "Beneficiaries of the Public Health Service" from the manual. The officials believe that the Central Office did not intend for VA to treat all PHS beneficiaries (including dependents of DOD personnel) while denying this same group treatment under a different section of the manual.

The lack of effective coordination between these Federal facilities demonstrates that savings and fewer referrals to distant facilities could result from increased interagency sharing. At the time of our study, VA was planning to meet and arrange sharing procedures with PHS since apparently nothing in the regulations precluded sharing. Miami VA had planned to request clarification from VA's Central Office about the apparent inconsistent regulation noted above, however.

Tampa area

The Tampa PHS Outpatient Clinic provides general medical and dental services and purchases specialized services, such as radiology, dermatology, and orthopedics from local physicians. Inpatient care is provided by community sources, the New Orleans PHS Hospital, and MacDill Air Force Base Hospital. In 1976 PHS purchased over $12,000 in outpatient services and $224,000 in inpatient services from community providers.

During 1976 the PHS Clinic purchased 13 different types of services from community sources, including cardiology, ophthalmology, and psychiatry, both inpatient and outpatient. Tampa VA Chiefs of Psychiatry; Ear, Nose, and Throat; Ophthalmology; and Nuclear Medicine stated that their units could have provided services to PHS without an increase in personnel. The Tampa VA Hospital Director further stated that VA could have assumed all of PHS community-purchased workload except for neurology and orthopedic services. From a limited sample of 15 PHS psychiatric; ear, nose, and throat; and urology patients treated at community facilities, an estimated $14,000 could have been saved if VA had been used.

Since Tampa PHS spent about $236,000 during 1976 for services that VA could have provided, a potential for savings does exist.

However, according to PHS headquarters officials, a distinction should be recognized between PHS operating procedures and those of other Federal providers which may limit savings through sharing in certain geographical areas. PHS expenditures for care from non-Federal sources largely represent expenses incurred for care provided to eligible beneficiaries by contract physicians. Contract physicians are generally located in geographical areas which have no Federal health care facilities. Therefore there is generally no other alternative source of treatment except the PHS contract physician.

The Tampa PHS Clinic Director was unaware that VA regulations permitted PHS beneficiaries, who were not veterans, to be treated in VA facilities. Therefore, he stated that VA hospitals were not usually considered as an alternative to civilian hospitals or the New Orleans PHS Hospital because the majority of PHS beneficiaries were nonveterans and, he believed, ineligible for VA care. He also stated that in most instances, especially emergencies, patients go to hospitals before the clinic is notified.

(Currently this is normal PHS procedure for providing care to its beneficiaries on a nationwide basis.) However, he acknowledged that in some cases the patients' condition would allow referrals to VA. He said that before he could send a PHS beneficiary to Tampa VA, he would have to request approval from the New Orleans PHS Hospital.

CASE STUDY 16

SHARING LAW PRECLUDES VA FROM PROVIDING SERVICES TO AIR FORCE

In May 1977 representatives from the Tampa area Federal health care providers--Tampa VA, MacDill Air Force Hospital, the PHS Clinic, and the Coast Guard--met to discuss sharing medical services. This meeting was the first attempt to explore the possibility of local Federal medical facilities sharing services. Before the meeting there had been minimal contact between the area's Federal medical facilities. Tampa VA, for example, had provided only a limited amount of medical services to other Federal facilities, specifically some physical examinations and hospitalization for active duty military members pending disability retirement and becoming VA beneficiaries.

The possibility of MacDill obtaining radiology services from Tampa VA was discussed at the meeting. MacDill needed radiology services which would cost about $240,000 annually to purchase from private providers. VA estimated that it could meet MacDill's needs for an annual cost of $120,000--a savings to the Air Force of $120,000 a year.

In June 1977 Tampa VA sent a proposed sharing agreement to VA's Central Office requesting approval for VA to provide radiology services to MacDill. The proposal stated that:

> "* * * The radiology services of this hospital has had no difficulty in recruiting physicians in that specialty. We would have no difficulty over a period of time of adding to the professional staff. On the basis of this knowledge, we have reviewed MacDill's workloads and felt we could easily provide the services for $120,000 a year. This would give us adequate funds to recruit two radiologists and a clerk typist for transcription work. The MacDill Air Force Base would deliver the [X-ray] films to be read to the Veterans Administration Hospital."
>
> * * * * *
>
> "This hospital is perfectly willing, in the spirit of Federal cooperation, to provide this service to the MacDill Hospital. It would be necessary that the hospital be allowed to accept these funds from MacDill, similar to the current

> practice the VA employs in sharing agreements with other universities and hospitals. This money is obviously necessary for the cost of the personnel required * * *"

* * * * *

> "This is an excellent opportunity for the hospital and the VA to demonstrate a willingness and ability to perform a service for another Federal agency. It is evident such arrangements would save tax dollars."

VA's sharing law prevented the agreements from being approved. VA's Central Office denied the request for several reasons. First, the proposal indicated it would be necessary to recruit two radiologists and a clerk typist to serve MacDill's need. The Central Office stated that VA has no authority under a sharing agreement to recruit personnel for serving nonveterans' needs. Second, VA's sharing law permits VA to share only specialized medical resources that are unique in the medical community or can be fully used through mutual use. Since Tampa VA stated that MacDill's needed services are available in the community, they could not be considered unique. Lastly, since Tampa VA was not able to meet MacDill's need with the present staff, the requirements for maximum use through mutual use could not be met.

CASE STUDY 17

REGULATIONS RESTRICT SHARING BETWEEN VA AND AIR FORCE

In the Tampa and Miami areas, several regulations restricted treatment of Air Force dependents in VA facilities and directed intraagency transfer of DOD patients or referral to CHAMPUS instead of using another Federal agency's capability.

During 1976 MacDill Air Force Hospital in Tampa obtained various health services through the aeromedical evacuation system, CHAMPUS, and contracts with local civilian sources. Nearby Tampa VA could have performed some of these services. Pathology and nuclear medicine laboratory tests were the two most predominant services obtained, accounting for about $40,000, or about one-fifth of MacDill's 1976 supplemental care budget. A MacDill official said that a few patient specimens had been sent to Tampa VA, but most had been sent to a private laboratory.

Tampa VA's Director said that VA would have welcomed MacDill's laboratory work. The Chiefs of Tampa VA's Laboratory and Nuclear Medicine Services said that all MacDill's laboratory testing procured from private laboratories could have easily been performed at Tampa VA except for a few specialized tests.

Two obstacles to sharing were identified concerning VA's performing laboratory tests for MacDill: (1) questions about costs and (2) reimbursement to the providing facility.

MacDill said it would be willing to share with VA if there were a cost savings. VA's Chief of Laboratory Services said that the testing could be done at a slightly lower cost and service would have been more responsive than in the private laboratories. On the other hand, the Chief of Nuclear Medicine said the cost in his section would have been slightly more than in private laboratories. But VA performs the tests in duplicate to increase reliability, and it provides consultation regarding diagnostic indications. Neither service is normally provided by the private laboratories. Thus, VA prices would apparently have been at least competitive.

However, the Tampa VA Hospital Director said the major obstacle to sharing laboratory services was that the hospital needed additional funds to pay for supplies used to perform MacDill's tests. He believed this could be accomplished by Tampa VA and MacDill entering into a formal sharing agreement under 38 U.S.C. 5053. Tampa VA would then charge for supplies used and retain the funds. MacDill officials, however, had just recently become aware that they could enter into an agreement with another Federal hospital. Consequently, at the time of our study no firm progress toward sharing laboratory services had been made.

A similar situation existed between the Miami VA Hospital and Homestead Air Force Hospital. Homestead acquired a wide variety of health services from outside sources in 1976 through the aeromedical evacuation system, CHAMPUS, and contracts with local civilian sources for supplemental care. Neurology and nuclear medicine were the two most predominant services obtained for which Miami VA had capability. During 1976, 51 neurology inpatients were air evacuated to other DOD hospitals and 100 nuclear medicine scans were procured from private sources using Homestead's supplemental funds.

All 51 neurology inpatients were given a routine air evacuation precedence, and most were classified as either walking or mobile. Only three were classified as immobile. In addition, eight patients were air evacuated to military hospitals in Georgia, Mississippi, and Texas for nuclear medicine scans. All were given routine precedence and classified as walking or mobile. This is a questionable use of the air evacuation system, particularly when excess Federal capability existed nearby.

Miami VA's Chief of Neurology and Chief of Nuclear Medicine believed their services could have handled all 51 neurology inpatients and could have performed 90 of the 100 scans. However, Homestead officials were unsure of their authority to enter into a formal sharing agreement and had made no attempt to negotiate one.

In addition Homestead and Miami VA identified administrative regulations as major obstacles to sharing. The overriding obstacle was an Air Force regulation requiring intraagency transfer of patients. Secondary was VA's regulation which impedes DOD dependents from being treated in a VA facility.

Two military directives were cited by both Homestead and MacDill as obstacles to sharing. DOD Directive 5154.6, dated November 26, 1974, states that:

> "In order to provide for patient welfare and assure best use of hospital specialty services and bed availabilities, patients will be regulated--unless otherwise directed--to the nearest uniformed services medical treatment facility which is capable of providing the required care."

In addition, Air Force Regulation 168-10, dated July 22, 1974, establishes the following order of priority for obtaining medical services not available at an Air Force facility:

1. Another uniformed services medical facility.
2. A VA medical facility.
3. A civilian source.

Homestead and MacDill officials stated that they have obtained most of their supplemental care for active duty patients from the first priority listed by evacuating the patient to another DOD medical facility. While active duty patients are the primary recipients of this service, dependents and retired personnel may also be transferred. However, the officials stated that most dependents and retired personnel do not prefer to be transferred to another DOD facility because of the distance. They subsequently request that supplemental care be furnished locally. Because VA regulations impede the routine treatment of dependents at VA facilities, Homestead and MacDill have bypassed the second priority (VA medical facilities) and have purchased the needed services from civilian sources or through CHAMPUS. A major factor in the decision to use CHAMPUS is that the program is not paid for from the military hospital's budget. The same is true for the air evacuation system. If patients were transferred to VA, the hospital would be charged for services.

Homestead and MacDill officials told us that military dependents are a substantial portion of their workload. Because of a VA regulation restricting dependents from being treated in VA facilities, Homestead and MacDill have made few efforts to request medical services from VA.

CASE STUDY 18

LACK OF COORDINATION AND REGULATIONS PRECLUDE SHARING BETWEEN NAVY AND VA

While there is an apparent excess of some medical services at the Key West Naval Hospital, Florida, many veterans living in the area are traveling about 160 miles for treatment at the Miami VA Hospital. Area veterans are also being treated by community providers, when some could possibly be treated at the Naval Hospital. Navy and VA have not coordinated efforts in the area, and Navy identified two regulations which would preclude sharing with VA. VA would be interested in establishing cooperative arrangements with Navy. Such arrangements could benefit VA patients and more fully use existing Federal capabilities.

In recent years the Key West Naval Hospital has been experiencing a declining patient workload. It was originally built to accommodate 200 beds, but reductions have occurred in the last 3 fiscal years to 70, 48, and finally 39 beds. Navy officials said the reductions were due to a reduced mission since the Vietnam crisis concluded. In 1976 the inpatient occupancy rate averaged 81 percent--35 persons daily--and an average of 19 physicians were on board throughout the year. About 8,600 outpatient visits were recorded each month during 1976, an average monthly workload for each physician of 452. In comparison, each physician's average monthly outpatient workload at Homestead Air Force Hospital during the same period was 649.

For the first 6 months of 1977, Key West Naval Hospital's occupancy rate decreased from 20 patients in January to 13 patients daily in June. For this period the average occupancy rate was 48 percent, or 19 persons daily. Outpatient visits for the same period also decreased to a monthly average of almost 6,200. This amounts to an average monthly outpatient workload for physicians assigned during July 1977 of 388.

These statistics indicate that the Key West may have some excess inpatient and outpatient capacity, which VA beneficiaries could possibly use. VA has estimated that over 9,000 veterans live in Monroe County, where Key West is located. Miami VA records showed 35 Key West area veterans had been treated from May to August 1977. They live closer to the Key West Naval Hospital than the Miami VA. From Key West to Miami is a trip of about 160 miles on hazardous roads. From an analysis of the services these 35 veterans received at Miami VA and the services available at Key West, we believe at least 12 could have been treated at the Naval Hospital. Ten were outpatients and 2 were inpatients. Conditions treated ranged from pneumonia (inpatient) to a hernia, an ear infection, and a swollen right knee (all outpatients). Treatment data were not available for 11 more patients who lived closer to the Naval Hospital than VA, but some of them could possibly also have been served by Navy.

In addition, a Bay Pines, Florida, VA official who maintains centralized data on outpatient services purchased from private physicians by veterans in VA Medical District No. 12 told us that 141 medical treatment information cards have been issued to veterans living in the city limits of Key West. These cards are issued to veterans who live a great distance from a VA facility and desire to obtain outpatient medical treatment for a recurring illness from local private physicians or another Federal medical facility. VA reimburses the Federal facilities their actual costs and pays the private physicians reasonable fees. The limit is $40 monthly unless the doctor submits a medical plan to VA for approval to exceed the limit. The official also said experience has shown that the 141 veterans have spent an average of $60 monthly each--about $8,500 monthly, or $102,000 annually. Consequently, VA is raising the limit to $60 a month. We believe that some of these 141 veterans could possibly be treated at the Key West facility if Navy would allow it.

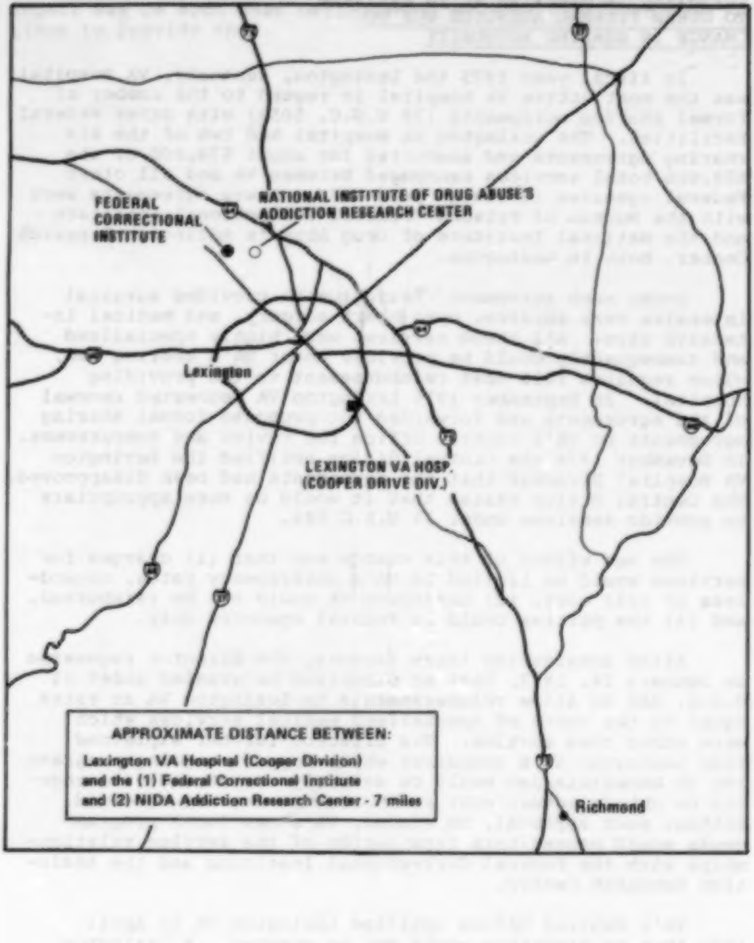
According to the Bay Pines VA official, most VA cards have been issued in the Pensacola area of Florida. The nearest VA facilities are about 200 miles from Pensacola, so the U.S. Naval Hospital, Pensacola, and Eglin Air Force Base Hospital have been very cooperative and treated many card-carrying VA patients in the area. However, the Key West Naval Hospital had refused to see VA patients for about 3 years. The official said that the reasons offered by Key West for not serving veterans were (1) it had no mission to serve veterans and (2) it lacked sufficient staff to serve veterans.

Further, Key West Naval Hospital's Commander told us that Navy's mission does not include providing service to veterans or any other Federal beneficiary. He said he would oppose the idea of providing service to anyone outside Navy's mission.

Several VA officials in Florida said a veterans organization was requesting VA to establish an outpatient clinic and a small inpatient facility in Key West. This would prevent veterans living in the area from having to drive over 100 miles for treatment at Miami VA. The officials also said they were very interested in making an arrangement with the Key West Naval Hospital to share facilites rather than establish a new VA facility.

This appears to be an excellent opportunity for interagency sharing in the in the Key West area. Veterans living in the area could benefit substantially from reduced travel, Navy facilities could be more optimally used, and Government expenditures for health services by the private sector could be reduced. Possibilities include a sharing agreement with Navy for treating veterans within existing capacity or through supplementing Navy staff with VA personnel.

SELECTED FEDERAL HOSPITALS IN THE LEXINGTON, KENTUCKY, AREA


FEDERAL CORRECTIONAL INSTITUTE
NATIONAL INSTITUTE OF DRUG ABUSE'S ADDICTION RESEARCH CENTER
Lexington
LEXINGTON VA HOSP. (COOPER DRIVE DIV.)
Richmond
APPROXIMATE DISTANCE BETWEEN:
Lexington VA Hospital (Cooper Division) and the (1) Federal Correctional Institute and (2) NIDA Addiction Research Center - 7 miles

CASE STUDY 19

POTENTIAL TERMINATION OF VA SERVICES TO OTHER FEDERAL AGENCIES DUE TO CHANGE IN SHARING AUTHORITY

In fiscal year 1976 the Lexington, Kentucky, VA Hospital was the most active VA hospital in regard to the number of formal sharing agreements (38 U.S.C. 5053) with other Federal facilities. The Lexington VA Hospital had two of the six sharing agreements and accounted for about $78,000 of the $99,000 total services exchanged between VA and all other Federal agencies in fiscal year 1976. These agreements were with the Bureau of Prisons' Federal Correctional Institute and the National Institute of Drug Abuse's Addiction Research Center, both in Lexington.

Under each agreement, Lexington VA provided surgical intensive care service, open-heart surgery, and medical intensive care. All these services were highly specialized and consequently could be provided under VA's sharing law, which requires full cost reimbursement to the providing hospital. In September 1976 Lexington VA requested renewal of the agreements and forwarded the proposed formal sharing agreements to VA's Central Office for review and concurrence. In December 1976 the Central Office notified the Lexington VA Hospital Director that the agreements had been disapproved. The Central Office stated that it would be more appropriate to provide services under 31 U.S.C 686.

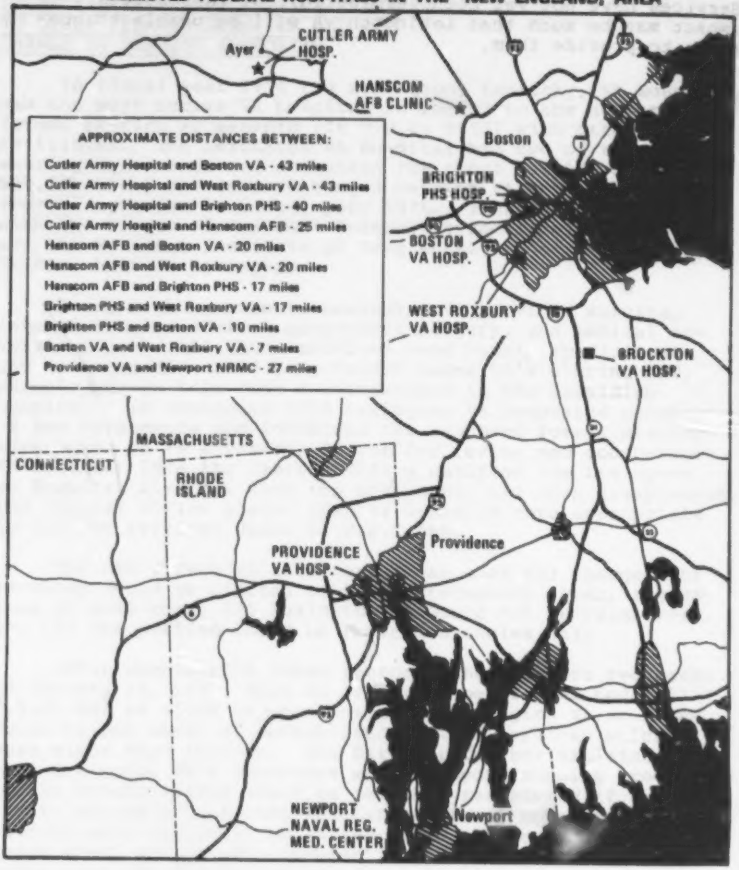
The net effect of this change was that (1) charges for services would be limited to VA's interagency rates, regardless of full cost, (2) Lexington VA would not be reimbursed, and (3) the parties could be Federal agencies only.

After considering these factors, the Director requested on January 24, 1977, that an exception be granted under 31 U.S.C. 686 to allow reimbursements to Lexington VA at rates equal to the costs of specialized medical services which were other than routine. The Director further explained that Lexington VA's resources which support ongoing programs for VA beneficiaries would be severely restricted if authority to obtain actual cost reimbursement was not received. Without such approval, he stated, VA's own local program needs would necessitate termination of the service relationships with the Federal Correctional Institute and the Addiction Research Center.

VA's Central Office notified Lexington VA in April 1977 that an exception would not be granted. A Lexington

VA official told us that as a consequence, Lexington VA has not been able to recover the costs of these services. Services have not yet been terminated, but the budgetary impact may be such that Lexington VA will be unable to continue to provide them.

SELECTED FEDERAL HOSPITALS IN THE NEW ENGLAND, AREA



APPROXIMATE DISTANCES BETWEEN:

Cutler Army Hospital and Boston VA - 43 miles
Cutler Army Hospital and West Roxbury VA - 43 miles
Cutler Army Hospital and Brighton PHS - 40 miles
Cutler Army Hospital and Hanscom AFB - 25 miles
Hanscom AFB and Boston VA - 20 miles
Hanscom AFB and West Roxbury VA - 20 miles
Hanscom AFB and Brighton PHS - 17 miles
Brighton PHS and West Roxbury VA - 17 miles
Brighton PHS and Boston VA - 10 miles
Boston VA and West Roxbury VA - 7 miles
Providence VA and Newport NRMC - 27 miles

Ayer
CUTLER ARMY HOSP.
HANSCOM AFB CLINIC
Boston
BRIGHTON PHS HOSP.
BOSTON VA HOSP.
WEST ROXBURY VA HOSP.
BROCKTON VA HOSP.
MASSACHUSETTS
CONNECTICUT
RHODE ISLAND
PROVIDENCE VA HOSP.
Providence
NEWPORT NAVAL REG. MED. CENTER
Newport

CASE STUDY 20

INTERAGENCY SHARING OCCURS IN NEW ENGLAND, BUT CERTAIN OBSTACLES STILL EXIST

DOD, VA, and PHS facilities in the greater Boston area are sharing some services, but questions about proper sharing authority, beneficiary eligibility, and reimbursement procedures hamper increased sharing. Current sharing is informal and occurs because of local initiative and cooperation. However, sharing in certain other Federal facilities in New England is rare.

Interagency sharing in the greater Boston area takes place between Cutler Army Hospital, the PHS Hospital, the Boston and West Roxbury VA Hospitals, and the Hanscom Air Force Base Clinic. The officials we spoke with generally agreed that current sharing is being done out of necessity. The DOD facilities and the PHS Hospital need many services available at the VA Hospitals, and the VA Hospitals have made their services available. In certain instances services have also been provided between non-VA facilities.

Boston and West Roxbury VA have the widest range of specialized services available of any of the Federal facilities in the greater Boston area. Consequently, they act as referral centers for other VA hospitals and provide some services to the PHS Hospital and DOD facilities in the area. As of May 31, 1977, they had provided other Federal agencies almost $243,000 in services during fiscal year 1977. These services involved a total of 141 inpatients and 247 outpatient visits.

Confusion about sharing agreements

Cutler's Commander said he isn't authorized to enter into formal sharing agreements. However, he did not think such agreements were needed or desirable. The Commander stated that the current informal arrangements are working very well. Using an informal arrangement the PHS Hospital accepts any patient Cutler refers, if the service is available, as do Boston and West Roxbury VA. The only exception is that the VA hospitals will not accept dependents. The Commander said VA regulations prohibit VA from accepting military dependents.

On the other hand, the PHS Hospital Director said:

--He would like to have formal agreements with the VA Hospitals.

--Although VA is not formally committed to providing the services, the VA hospitals have been very cooperative in accepting PHS patients, particularly for outpatient tests.

--A formal agreement with VA would give him some assurance that the services would continue to be available.

--The PHS hospital does not need formal agreements with the DOD facilities for which it provides services because they are all members of the uniformed services.

Boston VA's Hospital Director told us that he would like to have sharing agreements with the other Federal facilities to which he is currently providing services, but that he isn't authorized to enter into such agreements. He meant that there is nothing in the VA regulations which, in his opinion, permits formal agreements with other Federal facilities. The director cited VA's "Program Guide for Sharing Specialized Medical Resources." A paragraph on "Authority to Share" mentions only community hospitals, and the director said he does not interpret this to include Federal facilities. The director emphasized, however, that he does not believe he is prohibited from providing services to other Federal facilities as long as it does not affect care for veterans, but that the sharing must be informal.

In subsequent discussions with the director's staff, it became apparent that there was a great deal of confusion over the issue of sharing agreements with Federal agencies. The director and his staff concluded that formal agreements could be made and cited two authorities. Boston VA officials said that under the first, the Economy Act, agreements could be made for general sharing of all types of services and under the second, 38 U.S.C. 5053, specialized medical resources could be shared.

West Roxbury VA's Hospital Director, also Director of VA Medical District I, favors increased Federal sharing. He has regularly attended meetings of the Tri-service Military Medical Region X, New England Subcommittee, to encourage other Federal facilities to more fully use VA hospitals. According to the director, West Roxbury VA has been accepting referrals (except dependents) informally from other Federal facilities since 1971 for all services available at West Roxbury. The director said that formal agreements with other Federal hospitals aren't needed and that there are advantages to not having them. He stated that the current informal procedure based on doctor-to-doctor referrals makes it simple to refer patients from other Federal facilities to a VA hospital.

Other hospitals in the New England area do not have the close working relationships discussed by West Roxbury's Director. For example, Newport Naval Hospital and the Providence VA Hospital are 30 miles apart but rarely share, although certain capabilities could be shared. Newport Naval Hospital refers patients to another naval hospital in Connecticut, to the PHS Hospital near Boston, or to community hospitals or air evacuates them to other military facilities. Very few patients are sent to Providence VA. In fact, several chiefs of services at Newport said they do not know what services are available at Providence VA--even though it is the closest Federal facility--never consider it for referrals, and think of VA as a completely separate system.

Even though Providence VA is operating close to capacity, some services might have been provided to patients from Newport. The Providence VA Chief of Staff reviewed a list of Navy patients that Newport had air evacuated to other military hospitals or sent to community hospitals and concluded that many could probably have been treated at Providence. Simple, clear procedures for interagency sharing which are inherent in a formal program structure would do a lot to identify possible sharing opportunities in all areas of the country and complement those instances when individual initiative has already promoted interagency sharing.

Reimbursement obstacles

Federal facilities in New England which provide services to other Federal agencies' beneficiaries do not charge full cost for services. Instead, standard interagency rates are charged. For example, in fiscal year 1977 VA hospitals billed other agencies $116 for each inpatient day and $39 for each outpatient visit, PHS billed $117 for each inpatient day and $25 for an outpatient visit, and DOD billed $168 per inpatient day and $20 per outpatient visit.

None of the providing hospitals are reimbursed nor do they receive increased allocations from their headquarters based on the reimbursements. They do, however, include services to other agencies in their workload statistics on which their subsequent years' budgets are based.

The Boston VA Hospital Director told us the lack of local reimbursement was an obstacle to sharing. However, he believed local reimbursement was made only under formal sharing agreements (38 U.S.C. 5053) involving non-Federal community hospitals.

West Roxbury VA's Hospital Director also believes that the lack of local reimbursement is an obstacle. We told him VA's Central Office returns the reimbursement to the local VA hospital under formal sharing agreements. The Director stated that this is true when the agreements are with non-Federal facilities but not with other Federal facilities. He believed that in the case of Federal facilities, reimbursement occurs only at a higher level.

Inconsistent beneficiary eligibility

Cutler refers patients to the two Boston VA Hospitals and the PHS Hospital in Brighton, Massachusetts. Cutler's policy is that active duty people will be sent to these hospitals instead of community facilities, because such services are not paid from Cutler's operating funds. On the other hand, if active duty people are sent to community facilities, Cutler must pay from its own budget. The officials also stated that they do not send dependents to the VA hospitals because VA is not allowed to accept them. However, they do send dependents, when possible, to the PHS hospital--about 45 miles away.

The PHS Hospital Director favors interagency sharing. In 1976 he added a Health Benefits Coordinator to his staff to oversee PHS use of other medical facilities. One of the coordinator's primary responsibilities is to insure that other Federal hospitals are used when possible, instead of community hospitals.

The PHS Hospital refers its beneficiaries, including dependents, to VA and community facilities primarily for specialized outpatient tests. From January to mid-May 1977, 2 PHS medical departments scheduled 302 appointments at other medical facilities. Of these, 251 were at the 2 local VA Hospitals (151 at the Boston VA and 100 at the West Roxbury VA). The remaining 51 appointments were at community hospitals. The majority of the appointments were for nuclear medicine scans. Appointments for dependents accounted for 88 of the 251 appointments.

The PHS Hospital Director stated he knew that VA, according to its regulations, was not supposed to accept dependents, but believed that VA was doing it as an accommodation to PHS. The Boston VA Hospital Director said he was not aware of this practice and he would look into it to determine the authority for doing so. Subsequently, the Boston VA Hospital's Chief of Medical Administration Services told us that VA Manual M-1, part 1, chapter 15, prohibits VA hospitals from accepting dependents. However, he then stated that VA Regulation 6046(B)(2) applies to the dependents sent by the PHS Hospital. According to the Chief, this regulation allows VA hospitals to care for PHS beneficiaries. He stated that this means that if a PHS beneficiary is sent to the VA hospital with proper authorization and PHS will pay the bill, then the VA hospital may provide the service.

This regulation states that "Hospital care may be provided, upon authorization, for beneficiaries of the Public Health Service * * * and other Federal agencies." If the Chief's interpretation of this regulation as it pertains to PHS is correct, then it seems that the latter part of the regulation would also allow them to accept dependents from other agencies (i.e., DOD).

Opportunities for increased sharing

As noted previously, some sharing is already occurring between the Boston area Federal medical facilities. Nevertheless, opportunities exist for more sharing even though some facilities have limited capabilities and others are already operating at close to capacity.

Air-evacuated patients

We were told by VA officials that 51 of the 62 patients air-evacuated from Cutler to other military medical facilities from October 15, 1976 to March 22, 1977 could have been treated at the West Roxbury VA or a VA psychiatric hospital at Bedford, Massachusetts. An additional 7 patients--dependents of active duty or retired personnel--could have been treated but VA said it had no authority to treat such individuals. Of these 58 patients who could have been treated locally, 43 were sent to Walter Reed Army Medical Center, about 400 miles away, and the others to various military facilities across the country.

Although we could not determine the savings which could be realized by using local Federal hospitals, we believe that routing specially equipped airplanes to military installations to pick up possibly just one patient is wasteful when that patient could have been treated at a nearby Federal facility. Additionally, according to an Air Force official, air evacuation separates the patient from his/her family and can result in the patient spending several days in transit before reaching his/her destination.

CHAMPUS patients

The Directors of both Roxbury VA and Boston PHS agreed that they could handle a larger workload, particularly inpatients, but cautioned that additional resources to support ancillary services currently operating at capacity might be required. Both Directors believed it would be much less expensive for the Government to treat Federal beneficiaries in Federal facilities than to use community hospitals.

We asked officials at both hospitals to review lists containing services provided under CHAMPUS during fiscal year 1976 in the greater Boston area. According to these officials, almost every service listed is available at one or both hospitals. Because the dates on which services were provided were not available, the directors could not say definitely that they could have provided all the services, but they indicated they could have provided many of them.

It appears that certain Federal beneficiaries currently being treated under the CHAMPUS program could be treated in other Federal hospitals.

A BILL

To assure the development and implementation of policies and procedures to make more efficient and effective use of existing Federal medical resources.

TITLE I

Section 101 - Short title

This Act may be cited as the "Federal Medical Resources Sharing and Coordination Act of 1978".

Section 102 - Findings and Purpose

(a) The Congress finds that:

(1) Unnecessarily duplicative or underutilized medical resources exist in individual Federal direct health care facilities within the same geographical area.

(2) Federal agency direct health care providers are not routinely sharing their medical resources with other Federal providers.

(3) Opportunities exist for greater interagency sharing of medical resources without any detrimental effect upon the providing agency's primary beneficiaries.

(4) Inadequate incentives currently exist within the various Federal direct health care delivery systems to make maximum use of Federal medical resources.

(5) Increased coordination among Federal agencies is needed to ensure continual availability of services to eligible beneficiaries, to maintain acceptable standards of health care quality, and to limit the effects of inflationary pressure upon operating costs by sharing Federal medical resources to the maximum extent feasible.

(b) Recognizing the need for an expeditious solution of the problems described in subsection (a), it is the purpose of this Act to (1) clarify and expand the authority for sharing medical resources among Federal agencies; and (2) facilitate the development of a comprehensive medical planning policy for Federal agencies responsible for the provision of direct health care.

Section 103 - Definitions

As used in this Act:

(a) "Direct health care" means any health care provided to an eligible Federal beneficiary in a facility operated by the United States Government, including inpatient care and any type of outpatient treatment, test, or examination.

(b) "Beneficiary" means any individual who is entitled by law to direct health care furnished by the United States Government.

(c) "Providing agency" means any executive or military department or establishment having statutory responsibility for the provision of direct health care.

(d) "Primary beneficiary" means an individual who is among those specifically entitled by law to direct health care in the facilities of a particular providing agency.

(e) "Negotiated cost" means the cost determined on a medical service-by-service, hospital-by-hospital basis to be an equitable and consistent charge for the service(s) provided. To the maximum extent feasible this cost should include all the costs funded from current appropriations.

Section 104 - Cooperative Sharing Arrangements

(a) The Secretary of Defense, the Secretary of Health, Education, and Welfare and the Administrator of Veterans Affairs are authorized and directed, within 120 days of the effective date of the Act, to establish guidelines pursuant to which the director or commanding officer of each health care facility of such providing agency will enter into cooperative sharing arrangements under which such health care facility will be utilized, whenever appropriate, by any beneficiary eligible for direct health care.

(b) Services to be shared among Federal health care facilities will not be limited to "specialized medical resources" as defined in 38 U.S.C. 5053 and 42 U.S.C. 254a. Instead, this Act requires sharing of any medical resources which are determined by the director or commanding officer of a Federal health care facility to be available and suitable for sharing.

(c) Such cooperative arrangements shall provide:

(1) That the availability of hospital or medical care to beneficiaries of an agency other than the providing agency shall be on a referral basis, and will not adversely affect care of the providing agency's primary beneficiaries.

(2) That the providing agency shall be reimbursed by the agency for whose beneficiary a medical service is provided. Reimbursement will be based on negotiated costs as agreed by the directors or commanding officers of the health care facilities involved.

(3) Reimbursement shall be credited when received by the providing agency to the appropriation from which the medical service was funded. The reimbursement shall be subsequently allocated to the specific facility that provided the medical service.

(d) Cooperative sharing arrangements will be negotiated and approved at the local operating level by the directors or commanding officers of the Federal health care facilities involved. Locally approved arrangements will be submitted to the respective agencies' headquarters offices for review (and disapproval if judged not to be in the best interest of the Federal Government). This requirement does not preclude facility directors or commanding officers from establishing and proceeding with agreements prior to headquarters review.

(e) Providing agencies are permitted to request funds from the Congress and to expand available funds as needed to acquire the resources necessary to treat beneficiaries of another providing agency when such actions would be in the best interest of the beneficiaries and the Federal Government.

(f) Executed cooperative sharing arrangements may be terminated within 90 days after notification in writing is given by the director or commanding officer of an involved facility.

Section 105

If any provision of this Act is inconsistent with any other provision of law insofar as it relates to dealings among Federal agencies, this Act will control.

TITLE II

FEDERAL MEDICAL CARE COORDINATION

Section 201

The Office of Management and Budget is directed to:

(1) assess the need for future development of Federal medical facilities, (2) exercise oversight responsibility for the planning of such facilities and (3) encourage and coordinate the sharing of Federal medical facilities and services to the maximum possible extent.

Section 202 - Authority and Functions

(a) The Office of Management and Budget shall provide overall direction in the form of policies and procedures for the furnishing of direct health care by the Federal Government. To the extent considered appropriate and with due regard to the program activities of the providing agencies, the Office of Management and Budget shall prescribe policies and procedures designed to maximize interagency sharing of health resources. All policies and procedures prescribed shall be followed by providing agencies in furnishing direct health care to or obtaining direct health care for their beneficiaries.

(b) The functions of the Office of Management and Budget shall include:

(1) establishing a system of coordinated, and to the extent feasible, uniform direct health care policies and procedures for the providing agencies;

(2) establishing criteria and procedures for an effective and timely method of soliciting the viewpoints of interested parties in the development of policies and procedures governing the provision of direct health care by the providing agencies;

(3) monitoring and revising policies and procedures relating to the relationships among the providing agencies; and

(4) establishing policies and procedures for coordinated planning for future development of the Federal direct health care delivery system.

(c) In developing policies and procedures to be established, the Office of Management and Budget shall consult with all affected agencies.

(d) The authority of the Office of Management and Budget under this Act shall not be construed to interfere with an agency's particular medical care responsibilities provided by law.

Section 203

The Office of Management and Budget shall annually submit to the Congress a report on the progress of Federal medical resource sharing and coordination of Federal health resources planning. Other reports may be submitted as necessary to keep the Congress informed of major Federal activities to increase sharing of Federal medical resources. Appropriate legislative recommendations shall be included in these reports.

Section 204

Each providing agency shall, upon presentation of its appropriations request for each fiscal year following the effective date of this Act, report to the committees on appropriations of the Senate and House of Representatives. The report shall detail each providing agency's activities pursuant to the cooperative sharing arrangements referred to in section 104 of this Act and other activities directed toward maximizing the efficient use of Federal health resources during the preceding fiscal year.

ASSISTANT SECRETARY OF DEFENSE
WASHINGTON, D. C. 20301

HEALTH AFFAIRS

April 5, 1978

Mr. Gregory J. Ahart
Director, Human Resources Division
General Accounting Office
Washington, DC 20548

Dear Mr. Ahart:

This is in response to your letter of January 31, 1978 to the Secretary of Defense requesting comments on a draft report entitled "Legislation Needed to Encourage Better Use of Federal Medical Resources and Remove Obstacles to Inter-agency Sharing." (OSD Case #4809) (GAO Code 10185)

The DoD supports the concepts of inter-service and inter-agency coordinated planning and delivery of health care. In this regard, the following comments are provided:

A DoD survey of the military medical departments revealed that a considerable amount of sharing already occurs among Federal health care providers. The nature of sharing agreements spans a broad range including manpower, equipment, facilities and knowledge. It includes ancilliary support services as well as direct medical services. The survey of existing sharing agreements revealed a general willingness rather than a reluctance to enter into agreements when such agreements are deemed beneficial by the activities or agencies concerned. Nevertheless, obstacles identified by the audit are real and, as the case studies reveal, frequently confound the establishment of sharing agreements. To the fullest extent possible, the obstacles should be eliminated.

As the report acknowledged, Federal health providers at the headquarters level have begun to work together in various ways, not the least of which is the creation of the Federal Health Resources Sharing Committee (FHRSC). The committee, composed of high-level representatives from the VA, USPHS, Army, Navy, Air Force and Office of the Secretary of Defense will operate under a charter tasking it to identify and promote opportunities for joint planning and use of health care resources in the Federal Government. The FHRSC is established to provide a forum for representatives from Federal agencies to interact in the cooperative exploration of joint planning and sharing opportunities in the delivery of medical services and the use of medical resources. (Attachment A) Two subcommittees have been established to explore planning and sharing opportunities and develop uniform Federal criteria and standards for cardiac catheterization laboratories and computed tomography scanner systems.

A recommendation in the report digest, page V, proposes that legislation be passed to establish a Federal policy directing inter-agency sharing of Federal medical resources "whenever appropriate." The same recommendation in the body of the report, page 55, uses the term "whenever possible." The former language is preferable in its recognition that what is possible is not necessarily appropriate.

The DoD concurs that sharing should be facilitated by enabling local hospital managers to negotiate sharing agreements under guidelines established by higher headquarters.

DoD concurs with the recommendation that the legislation permit agencies to expand services to treat beneficiaries of another Federal agency when such services would benefit the patient and the Government. The Economy Act, as pointed out in the report, has a limitation as to its effectiveness as a sharing authority in that it specifies that the providing agency must be able to provide a service without increasing its resources.

The draft report advocates the establishment of a policy requiring Federal facilities to use other Federal sources of care prior to referring patients to civilian providers or other remote distant facilities within their own health care system. The DoD concurs with the concept; however, patients should not be required to travel beyond 40 miles from their place of residence to obtain care from any source. The "40 mile radius rule" is the current guideline for issuance of non-availability statements. DoD non-concurs with the recommendation to require use of other nearby Federal hospitals prior to referring patients to other distant military hospitals. Conceptually DoD supports this policy, but on a case-by-case basis. Occasionally, a particular condition will warrant the exception because of its potential value to the military medical center and hospital teaching programs.

The GAO recommendation regarding modification of reimbursement mechanisms advances four separate proposals that represents change from existing mechanisms and will impact upon DoD. They will be addressed one at a time: (1) Base reimbursement on incremental costs. Non-concur. Reimbursement will be less complicated if based upon the recovery of full costs. In addition, a Comptroller General Decision B-136318, January 21, 1977 indicates that reimbursement for services among Federal agencies should be on the same basis as required by the User Charges Act for services provided to the general public, i.e., recovery of full costs. The GAO recommendation appears to be in conflict with that decision; (2) Establishment of fees on a service-by-service basis. Concur. When the Uniform Chart of Accounts for military hospitals, currently scheduled for full implementation on October 1, 1979, is in operation, the capability should then exist to identify costs for specific services to the degree that separate fees can be set for those services; (3) Establishment of fees on a hospital-by-hospital basis.

Non-concur. The military health care system does not operate on a fee-for-service basis since there is no requirement to recover costs for approximately ninety-nine percent of the services rendered; therefore, the system is neither now sophisticated enough, nor will it be after implementation of the Uniform Chart of Accounts, to allow rates to be established on a hospital-by-hospital basis. Rates for specific services should be centrally established; (4) Reimburse the hospital providing services. Concur that such a feature would provide more incentives to local hospital commanders to enter into sharing agreements.

In summary, the DoD is in solid agreement with the concept of sharing medical capabilities within the Federal sector. The audit report has been most helpful in focusing upon obstacles precluding further sharing. Legislation to remove such obstacles is warranted. The Federal Health Resources Sharing Committee is the most effective forum to promote sharing that results in increased effectiveness as well as economical and efficient use of Federal medical resources.

Thank you for this opportunity to comment on the draft report.

Sincerely,

Vernon McKenzie
Principal Deputy Assistant Secretary

Attachment (1)

GAO note: Page references in this appendix may not correspond to page numbers in this final report.

FEDERAL HEALTH RESOURCES SHARING COMMITTEE

Preamble

In recent years there have been unprecedented changes in the organization and delivery of health care in the United States. There are valid reasons to believe, moreover, that the trends demonstrated to date are only the beginning of a substantial redirection of the entire system. Burgeoning technology, rising costs, increasing consumer requirements, and fragmentation of the approach to the total health care of the individual suggest that new approaches are necessary to achieve the objectives of the health care system, both outside and within government. The Assistant Secretary of Defense (Health Affairs), the Surgeons General of the Armed Services, the Assistant Secretary for Health, DHEW (Surgeon General of the U.S. Public Health Service), and the Chief Medical Director of the Veterans Administration affirm their belief that one approach to the common objective of providing the highest possible quality of health care with greatest efficiency lies in the acceptance of common goals and an open approach to the sharing of resources. It is recognized that the broad goal of sharing resources to improve the overall quality of health care and reduce the excess consumption of scarce resources can be accomplished, in part, by coordinated planning arrangements between the signatories to this agreement.

Purpose

To identify and promote opportunities for joint planning and use of health care resources in the Federal Government. To provide a forum for representatives from Federal agencies to interact in the cooperative exploration of joint planning and sharing opportunities in the delivery of medical services and the use of medical resources. In pursuit of the primary objective of sharing Federal health resources, the Committee should consider the following:

a. Improving the quality, availability, and accessibility of patient care including patient comfort, convenience, and satisfaction.

b. Improving the efficiency with which patient care resources are expended.

c. Supporting attainment of the basic missions of Federal agencies participating in the agreement.

d. Promoting broad relationships with tertiary care institutions outside Government.

e. Promoting cooperative arrangements with non-Federal health providers, in areas of expensive specialized health services, in cooperation with health systems agencies.

f. Undertaking sharing programs in a way that supports training programs and enhances recruitment and retention of health care personnel.

g. Minimizing disruption of existing patient care and training programs.

Authority

The authority for this Committee to operate under the terms of this charter is derived from the authority vested by public laws and executive orders in the signatories of this charter.

The basic authority for sharing among Federal health care providers is established in such sources as:

31 USC 686 (Economy Act) - broad authority for interagency sharing

28 USC 5003 - facility and equipment sharing only (VA)

42 USC 254(a) - sharing specialized medical resources only (PHS)

38 USC 616 - DOD and PHS care for veterans if authorized by appropriation or other Act

38 USC 5053 - sharing specialized medical resources only (VA)

10 USC 1074(b) - VA provision of care for certain retirees only

10 USC 1074, 1076 - PHS provision of care for active duty military, retired and dependents and DOD care of other uniformed beneficiaries

The Committee shall ensure compliance with such authorities in proposing joint programs or sharing activities.

Organization

a. Membership. Each participating Federal agency or department shall assign representatives to serve on the Committee.

b. Chairmanship. Chairmanship shall rotate annually among agencies in an order determined by the members. It shall be the responsibility of the Chairman to coordinate arrangements for meetings by conveying the time, place, and agenda to all members. The Chairman shall ensure that minutes of meetings are recorded and distributed to members. Files and pertinent records shall be maintained by the Chairman.

c. Meetings. Meetings shall be held at times and places designated by the Chairman. Meetings shall be held not less than semi-annually.

Scope of Activities

a. Define and clarify scope of "joint planning" and "sharing."

b. Advise Federal agency officials on cooperative opportunities and constraints.

c. Identify and recommend legislative, regulatory, or other policy changes to enhance joint planning and sharing.

d. Initiate, validate and recommend coordinated programs with highest payoff in reducing unwarranted duplication or excess capacity without adversely effecting efficiency, effectiveness, readiness or quality of care.

e. Constitute subcommittees to explore the feasibility of joint planning and sharing arrangements in specific health care areas and to develop criteria and standards when appropriate. To establish milestones for subcommittee compliance. Initial working groups will be:

(1) Cardiac Catheterization Laboratory Subcommittee
(2) Computerized Tomography Subcommittee
(3) Mobilization Support Subcommittee
(4) Medical Information Systems Subcommittee

f. Clarify and recommend costing and funding provisions for interagency and sharing arrangements.

g. Support appropriate interfacing with the existing mobilization expansion agreement between the VA, DOD, and PHS.

h. Periodically assess and document the scope and extent of joint planning and sharing in effect for the purpose of facilitating further sharing through an exchange of such information.

Implementation

The Committee's recommendations will be implemented through existing agency and departmental structures and processes. Recommendations will be sent to each agency for action. If a concensus has not been achieved by the Committee, all agency recommendations will be included in the minutes.

Approval

Robert N. Smith, M.D.

Robert N. Smith, M.D.
Assistant Secretary of Defense
(Health Affairs)
Department of Defense

Julius B. Richmond, M.D.

Julius B. Richmond, M.D.
Assistant Secretary for Health
Department of Health,
Education, and Welfare

John D. Chase, M.D.
Chief Medical Director
Veterans Administration

Charles C. Pixley
Lieutenant General
The Surgeon General
U. S. Army

W. P. Arentzen

W. P. Arentzen
Vice Admiral, MC, USN
The Surgeon General
U. S. Navy

George Schafer

George E. Schafer
Lieutenant General, USAF, MC
The Surgeon General
U. S. Air Force

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
OFFICE OF THE SECRETARY
WASHINGTON, D.C. [illegible]

April 17, 1978

Mr. Gregory J. Ahart
Director, Human Resources
Division
United States General
Accounting Office
Washington, D. C. 20548

Dear Mr. Ahart:

The Secretary asked that I respond to your request for our comments on your draft report entitled "Legislation Needed to Encourage Better Use of Federal Medical Resources and Remove Obstacles to Interagency Sharing." The enclosed comments represent the tentative position of the Department and are subject to reevaluation when the final version of this report is received.

We appreciate the opportunity to comment on this draft report before its publication.

Sincerely yours,

Thomas D. Morris
Inspector General

Enclosure

GAO note: Page references in this appendix may not correspond to page numbers in this final report.

THE DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE (HEW) COMMENTS TO THE GENERAL ACCOUNTING OFFICE (GAO) DRAFT REPORT TITLED "LEGISLATION NEEDED TO ENCOURAGE BETTER USE OF FEDERAL MEDICAL RESOURCES AND REMOVE OBSTACLES TO INTERAGENCY SHARING."

GENERAL COMMENTS

The Department concurs with the general findings and recommendations of the GAO draft report. As indicated in the report, various aspects of the study have previously been coordinated with Department personnel and a number of actions which promote the broad objectives of the study have been taken. However, certain factors in the report require further development and the following comments are made to clarify specific issues contained therein:

- The report should be amended to reflect the progress made by the Federal Health Resources Sharing Committee (FHRSC). The report suggests that the FHRSC is a proposal, whereas the group has been chartered by senior officials in each agency, has organized itself and met, and has initiated study subcommittees to recommend standards for and sharing opportunities in Cardiac Catheterization Laboratories and Computerized Tomography Installations. Other subcommittees are being organized. (pp. ii, 15)

- The report tends to dismiss the work of the FHRSC before it has been given the opportunity to complete its first study. It should be recognized that a body such as the FHRSC is completely unprecedented. Its organization alone represents substantial progress, but most importantly this body has committed its sponsors to identify and overcome the largely administrative obstacles identified on pp. 20-33 of the report. Moreover, the committee represents a forum in which both existing law and new legislative proposals could be implemented. (p.iii)

- Any legislative proposal considered should clarify relationship between true primary and other Federal beneficiaries and contain a clear statement of the priority to be afforded to the primary beneficiaries. In addition, there should also be statements covering the missions of the facilities affected, patient access, convenience, quality of care, safety, and related concerns. (pp. IV, V)

- A number of questions are suggested concerning the proposal for legislation arising from the report. While there is no question that legislative relief from certain existing restrictions is necessary and that a Congressional mandate to share such as that embodied in the original Economy Act is desirable, the study should refrain from overly specific and restrictive guidelines which, while serving a need recognized today, may prove invalid later. Specifically, it is felt that any legislation proposed should only provide permissive authority to share, the sense of the Congress that interagency sharing is a priority concern, and general reimbursement guidelines. The specific reimbursement mechanism should be left to the agencies to develop within broad general agreements negotiated by the FHRSC or similar interagency organization. The incremental cost concept discussed on p. 53 of the draft is not an ideal vehicle of reimbursement. Further, it may not be supportable by existing cost-finding and other accounting tools available to the agencies concerned. Reimbursement should occur on a cost of service basis or, in some instances, it might be desirable to share resources by means of even exchange, an action that would represent a "true" sharing of capabilities. Ultimately, such action might lead to true Federal regionalization of services such as blood banking, specialized laboratory services, or specialized radiographic or nuclear medicine facilities and equipment. Also, legislation requiring reimbursement to the hospital concerned with providing services to another agency's beneficiaries is not desirable from the standpoint of administering entire systems since it would tend to unbalance the distribution of resources and create an undesirable competition for patients and the revenues they would represent. Rather, the hospital providing services should be funded on the basis of total workload, regardless of origin, with reimbursements paid centrally to be credited against the agency's total budget. Finally on this topic, a mechanism should be created to permit the development of facilities, equipment and personnel resources on the basis of extra-agency workload, with perhaps the proviso that such budgeting (now prohibited by the Economy Act) be based on long term agreements between the contracting agencies.

- Penalties for referral to another agency, rather than CHAMPUS, should be eliminated; i.e., an agency should not be required to fund referrals to other Federal agencies out of its own resources unless its CHAMPUS referrals are paid from the same resources. However, if the service can be obtained at lower cost privately, there should be no mandate to use a more costly Federal source of care. "Disengagement" under either vehicle should not be required. (p.35)

- While the Department has no objection to centralization of sharing coordination within OMB, it is emphasized that such coordination should be a managerial rather than budget process on the basis that the latter approach is retrospective, rather than prospective, affirmative, and guiding in its approach. (p.55)

- Sharing with non-Federal beneficiaries under clearly defined conditions should be authorized. This authority, similar to that given the PHS Hospital and Clinic System in Section 328 of the PHS Act, could be used to supplement local needs in areas where excess capacity is matched by an unserved or underserved need in the surrounding community. If carefully coordinated with local planning agencies in a manner to preclude interference with local resources, such action could provide a valuable supplement to existing local capabilities and national resources while improving utilization of Federal facilities.

The draft report also refers to the enactment of the National Health Planning and Resources Development Act of 1974 (P.L. 93-641) as recent major legislation designed to facilitate the sharing of the Nation's medical resources. The provisions of P.L. 93-641 require compliance by non-Federal hospitals and specifically exempts Federally operated facilities. However, the Department, on a voluntary basis, has subjected all Public Health Service hospital proposals (i.e. new facilities, modernizations, increased bed capacity, new special equipment) to the scrutiny of the Health Systems Agencies (HSAs) and State Health Planning and Development Agencies (SHPDAs) for ascertaining the appropriateness of such proposals. Moreover, it is not unusual for the HSAs and SHPDAs to review DOD and VA health care delivery proposals and send recommendations to the appropriate Federal agency. Both DOD and VA have informally agreed to consider the recommendations of the HSAs and SHPDAs, but they are not committed to make decisions which are in accord with the recommendations.

GAO RECOMMENDATION

We recommend that the Secretaries of Defense and Health, Education, and Welfare and the Administrator of Veterans Affairs act to:

----create an interagency task group (such as that currently being considered), made up of top-level Federal direct health care program administrators, the primary mission of which would be to encourage and expedite the implementation of a workable program of sharing Federal medical resources and

----direct the interagency task group to seek solutions to the administrative obstacles within each agency which impede the sharing of Federal medical resources.

DEPARTMENT COMMENT

We concur. The Charter of the Federal Health Resources Sharing Committee (FHRSC) has been approved by all agencies concerned. The approved charter directs the FHRSC to identify and eliminate obstacles to sharing, to prepare the FHRSC to identify and eliminate obstacles to sharing, to prepare guidelines for sharing and other cooperative arrangements for the agencies, to recommend actions to be taken when obstacles are not within the authority of the agency heads to resolve, and to establish subcommittees to deal with specific areas of concern. Initially, the FHRSC has formed subcommittees dealing with Cardiac Catheterization Laboratories and Computerized Tomography Installations. Other subcommittees dealing with Medical Information Systems and Mobilization Support are in process of formation. Reports from the Cardiac Catheterization and Computerized Tomography Subcommittees are expected by June, 1978.

VETERANS ADMINISTRATION
OFFICE OF THE ADMINISTRATOR OF VETERANS AFFAIRS
WASHINGTON, D.C. 20420

April 18, 1978

Mr. Gregory J. Ahart
Director, Human Resources Division
U. S. General Accounting Office
441 G Street, NW
Washington, DC 20548

Dear Mr. Ahart:

We appreciate the opportunity to comment on the January 31, 1978 General Accounting Office (GAO) draft report, "Legislation Needed to Encourage Better Use of Federal Medical Resources and Remove Obstacles to Interagency Sharing." All aspects of the report have been carefully reviewed and we offer the following comments.

In response to the recommendations to the Secretaries of Defense (DOD), and Health, Education and Welfare (HEW), and the Administrator of Veterans Affairs (VA) that we act to:

> --Create an interagency task group (such as that currently being considered), made up of top-level Federal direct health care program administrators, the primary mission of which would be to encourage and expedite the implementation of a workable program of sharing Federal medical resources, and
>
> --Direct the interagency task group to seek solutions to the administrative obstacles within each agency which impede the sharing of federal medical resources,

we would like to emphasize that the Department of Medicine and Surgery (DM&S) has provided impetus and direction in the development of a coordinated approach to health services planning by Federal agencies.

Initial meetings were held in the Office of the Assistant Chief Medical Director for Professional Services on August 4, August 8, and September 12, 1977, to explore joint Federal planning and sharing of specialized medical resources. Major discussion focused on establishing the organizational entity and the functional role of the task group. Subsequent meetings were held during November 1977, January, February and March 1978. The original group has been expanded by the addition of representatives of the three military services and the designation of the Deputy Assistant Secretary of Defense for Health Resources and Programs as the DOD representative. A formal charter developed for what is now called the Federal Health Resoures Sharing Committee (FHRSC) has been officially approved within each Agency.

The fast maturing role of the FHRSC is reflected in the positive actions being accomplished. Four initial study subcommittees are being established to formulate the basis for sharing decisions concerning cardiac catheterization, computerized tomography, mobilization support and medical information systems. Over time, the subcommittees are expected to develop standards for Federal providers in their designated field, to identify areas for potential sharing, and to present recommendations to the full Committee for sharing decisions. A consolidated list of existing interagency sharing arrangements is being assembled as a basis for further sharing considerations.

Administrative remedies for many of the reported impediments to interagency sharing are feasible without the need for further legislation. To the extent that there is inconsistency in the application of policies and procedures by individual health care facilities, as indicated by some of the cited case studies, this can be readily corrected by a redrafting and republication of VA policies and regulations to remove possible ambiguities and insure uniform interpretation and application.

This draft report also contains recommendations that the Congress enact legislation which would:

--Establish a policy that directs interagency sharing of Federal medical resources whenever possible.

--Authorize each Federal health provider to accept _all_ categories of direct care beneficiaries on a referral basis when it would be advantageous to the Federal Government and care of primary beneficiaries would not be adversely affected.

--Eliminate all restrictions on the types of medical services which can be shared between Federal facilities.

--Grant field hospital managers approval authority for arrangements between Federal facilities subject to headquarters veto only if judged not in the best interests of the Government.

--Permit agencies to expand services to treat beneficiaries of another Federal agency when such services would benefit the patient and the Government.

--Establish a policy requiring Federal facilities to use, if practical, other nearby Federal direct health care resources prior to referring patients for care under programs such as CHAMPUS, CHAMPVA, or to other distant facilities within their own health care system.

--Establish a standard method of reimbursement based on incremental costs between Federal hospitals with a provision to reimburse the hospital which provided the services to other Federal agencies' beneficiaries. This reimbursement mechanism would allow Federal hospital officials to agree upon equitable fees on a service-by-service, hospital-by-hospital basis.

In the same vein as our comments on the recommendations to DOD, HEW and the VA, and as recently testified to during the House Hearings on the VA 1979 budget request, the relatively new Interagency Committee on coordination and sharing of medical resources appears to offer an ideal mechanism for removing misunderstandings between and cooperation by the respective agencies involved.

We are opposed to the recommendation to establish a standard method of reimbursement based on incremental costs between Federal hospitals with a provision to reimburse the hospitals which provided the services. It is our position that reimbursement should be on actual costs which represent an average, uniform system rate, and not incremental or "out-of-pocket." The Agency's billing should not be based on two rates, one for Federal beneficiaries and another for non-Federal institutions. This could actually serve as a disincentive to sharing. If this recommendation becomes a part of the report, we feel the impact of such action should also be included. An incremental or "out-of-pocket" billing in lieu of actual costs will considerably reduce the amount of reimbursements presently being earned.

It should also be noted (see page 828 of the Appendix to the Budget For Fiscal Year 1979) that one of the Administrative Provisions related to VA appropriations states that, "No part of the foregoing appropriations shall be available for hospitalization or examination of any persons except beneficiaries entitled under the laws bestowing such benefits to veterans, unless reimbursement of cost is made to the appropriation at such rates as may be fixed by the Administrator of Veterans Affairs. (Department of Housing and Urban Development--Independent Agencies Appropriation Act, 1978)." Further, every appropriations act since the 1940's has contained the identical or a similar provision.

There are some other points we would like to bring out and ask that you consider including or correcting them in the final report.

In the section entitled, "LEGISLATIVE AUTHORITIES FOR SHARING FEDERAL MEDICAL RESOURCES," we feel credit for the VA's earlier efforts in interagency cooperation would be appropriate. Three examples follow:

--For many years, veterans were regularly admitted to the Philadelphia Naval Hospital if the 488 bed VA facility could not treat them.

--For a number of years there was a joint Bureau of the Budget/DOD/VA/HEW team responsible for reviewing future construction in the light of possible interagency cooperation.

--In the mid-1960's the Public Health Service (PHS) and VA worked together very well, with VA hospitals admitting PHS beneficiaries who no longer had access to Marine Hospitals which were closed (e.g. Chicago, Detroit, Memphis).

The section, "Time-consuming review of proposed sharing agreements," contains the statement, "the approval process can take more than 60 days if difficulties are encountered." While this is accurate in some instances--and all the case studies used by GAO in this report were problem situations--our average time for approval remains 21 work days. We do not believe this represents "time-consuming review."

Corrections should be made in the "Lack of standard reimbursement mechanism" section, because it indicates that only Interagency Agreement Reimbursements are to be deposited in a Treasury Account. All reimbursements collected must be deposited to a Treasury account. Reimbursements resulting from Interagency Agreements have been estimated--included in total anticipated workload--and funding has been allocated in advance in the Annual Target Allowance for each facility. Therefore, they are not available for reallocation as collected during the fiscal year. But anticipated reimbursements to be realized through Sharing Agreements are retained in a Treasury reserve account, (not allocated in advance in the Annual Target Allowance), and refunded quarterly, upon request, to the servicing facilities as reimbursements are collected.

The decision for this procedure did not occur 10 to 12 years ago and was not to make the budgeting process easier. In FY 1956, the Department of Medicine and Surgery adopted the Annual Target Allowance

System. This required the allocation of funds and workloads to each facility on an annual basis. To implement this new procedure, Total Budget Authority, plus anticipated reimbursements, became the base against which facility annual target allowance levels were established. It must be assumed that in the initial year of the annual target allowance consideration was given to the source of the reimbursements in making the distribution to each facility. Therefore, we do not feel that any maldistribution of the reimbursements ever existed.

Also in this report section, we would like to clarify that the redistribution, which totaled $33 million in FY 1977, is subject to adjustment from year to year based on workloads, rates and other known factors. This redistribution includes amounts "earned" under sharing agreements (offset by services purchased under sharing agreements), adjustments for exceeding or falling short of anticipated workload (which includes interagency agreements), and costs of furnishing reimbursable services to other VA appropriations or funds.

We wish to refute the statement in CHAPTER 3, CONCLUSIONS AND RECOMMENDATIONS, that the VA lacks an effective reimbursement mechanism and is inconsistent in its application. The VA seeks reimbursement for services rendered other Federal facilities in two ways--either by an Interagency Agreement or a Sharing Agreement. In both instances, actual costs are realized in accordance with present legislation. The method is negotiated at the facility level and forwarded to VA's Central Office for review and approval. We feel the present system is sound, but a reiteration of present policy could be helpful to all facility directors.

It has been our purpose up to this point to address specific issues or comments in the report. We believe we would be remiss, however, if we did not also address some of the basic policy issues which are associated with the recommendations contained in this report, or would affect their implementation.

The American people, acting through the President and the Congress, repeatedly have evidenced a special concern for its citizens who devoted part of their lives, usually their youth, to the defense of their country. Medical care has long been one of the primary areas where special care to veterans is provided. Originally, that care was provided by many components of the Federal government, as well as by some of the State agencies. In 1930, the establishment of the Veterans Administration consolidated these services into one Federal agency with a medical service responsible for all activities associated with the medical care and treatment of veterans, and in January 1946, Public Law 293 of the 79th Congress, created the Department of Medicine and Surgery within the Veterans Administration, and made it responsible for what has become the largest medical and hospital care system solely for the treatment of veterans.

By law, the VA is clearly responsible for providing complete care for veterans with service-connected disabilities. Its responsibility for nonservice-connected disabilities is primarily to veterans who are unable to pay for such care in other facilities.

The recommendations in this report seem to favor an amalgamation of resources for beneficiaries in the Federal sector. We are not unmindful of the need for cost containment, nor are we unmindful that additional efforts within the Federal sector may be able to accomplish a better utilization of resources. Any action we take, however, must be in accord with our primary mission of caring for veterans. Any new endeavor to share our resources, either within the Federal or the private sector, can only be considered if we are assured that it will not adversely affect our ability to accomplish our statutory obligation.

There is currently much controversy about how the nation's health care services should be obligated, delivered, and financed. Despite considerable pressure for change, there is still no agreement on which direction the change should take to produce the most desirable results. We realise that if a national health insurance program is established within the next few years, an important question will arise concerning the VA's role in that program. Because of this, and the fact that the President is still considering all of the options with respect to providing for the health care needs of the nation, as well as how the VA medical care system can best fit into the plans for the future, we believe it would be unwise to proceed immediately with legislation implementing the recommendations contained in this report. We also believe, as has been indicated, that administrative measures under way, or within reach, may be preferable to the legislative steps which the recommendations would entail. Finally, we cannot support the management and funding concepts advocated in the recommendations. It is our opinion that they are not in accord with accepted and recognized Federal agency management principles, and may be inadequate as a matter of law.

Again, we express our appreciation for the opportunity afforded us to comment.

Sincerely,

MAX CLELAND
Administrator

EXECUTIVE OFFICE OF THE PRESIDENT
OFFICE OF MANAGEMENT AND BUDGET
WASHINGTON, D.C. 20503

March 21, 1978

Mr. Gregory J. Ahart
Director
Human Resources Division
United States General
Accounting Office
Washington, D.C. 20548

Dear Mr. Ahart:

I am pleased to comment on your draft report, "Legislation Needed to Encourage Better Use of Federal Medical Resources and Remove Obstacles to Sharing."

This Office shares concern over many of the problems discussed in your report about sharing among Federal agencies. Your report is comprehensive, making many recommendations for extensive legislative and fiscal, as well as programmatic change. Lacking detailed analysis of the recommendations, and their potential impact, we cannot at this time indicate a position on the changes recommended for congressional consideration. However, we disagree with your recommendation that OMB establish a full-time staff group to work with the Federal agencies on improved sharing. I do not feel that this Agency should create a specific new unit solely for this purpose. Our full-time budget examiners and other OMB staff already work with the concerned agencies on a daily basis carrying out our role of budgetary and legislative analyses. This process allows us to explore individual and interagency issues and to recommend actions which are consistent among the agencies. Also, through our current process we can address interagency problems within the important focus of larger agency and national needs. A small, single-purpose unit would not be as efficient or effective as our current process, and for this reason, I feel we must approach this problem through our current organization.

I want to assure you that your report will be of great assistance to us in considering further actions to address sharing problems.

Sincerely,

W Bowman Cutter

W. Bowman Cutter
Executive Associate Director
for Budget

PRINCIPAL OFFICIALS RESPONSIBLE FOR ACTIVITIES DISCUSSED IN THIS REPORT

	Tenure of office	
	From	To
DEPARTMENT OF DEFENSE		
SECRETARY OF DEFENSE:		
Harold Brown	Jan. 1977	Present
Donald H. Rumsfeld	Nov. 1975	Jan. 1977
ASSISTANT SECRETARY (HEALTH AFFAIRS):		
Vernon McKenzie (acting)	Jan. 1978	Present
Robert N. Smith, M.D.	Sept. 1976	Jan. 1978
Vernon McKenzie (acting)	Mar. 1976	Sept. 1976
James R. Cowan, M.D.	Feb. 1974	Mar. 1976
DEPARTMENT OF THE ARMY		
SECRETARY OF THE ARMY:		
Clifford L. Alexander, Jr.	Feb. 1977	Present
Martin R. Hoffman	Aug. 1975	Jan. 1977
THE SURGEON GENERAL:		
Lt. Gen. Charles C. Pixley	Oct. 1977	Present
Lt. Gen. Richard R. Taylor	Oct. 1973	Oct. 1977
DEPARTMENT OF THE AIR FORCE		
SECRETARY OF THE AIR FORCE:		
John C. Stetson	Apr. 1977	Present
Thomas C. Reed	Jan. 1976	Apr. 1977
James W. Plummer (acting)	Nov. 1975	Jan. 1976
THE SURGEON GENERAL:		
Lt. Gen. G. E. Schafer	Aug. 1975	Present
DEPARTMENT OF THE NAVY		
SECRETARY OF THE NAVY:		
W. Graham Claytor, Jr.	Feb. 1977	Present
J. William Middendorf II	June 1974	Feb. 1977
J. William Middendorf II (acting)	Apr. 1974	June 1974

	Tenure of office From	To
DEPARTMENT OF THE NAVY (continued)		
THE SURGEON GENERAL:		
Vice Adm. William P. Arentzen	Aug. 1976	Present
Vice Adm. Donald L. Custis	Mar. 1973	July 1976
DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE		
SECRETARY OF HEALTH, EDUCATION, AND WELFARE:		
Joseph A. Califano, Jr.	Jan. 1977	Present
David Mathews	Aug. 1975	Jan. 1977
ASSISTANT SECRETARY FOR HEALTH:		
Julius B. Richmond, M.D.	July 1977	Present
James Dickson, M.D. (acting)	Jan. 1977	July 1977
Theodore Cooper, M.D.	May 1975	Jan. 1977
Theodore Cooper, M.D. (acting)	Feb. 1975	Apr. 1975
VETERANS ADMINISTRATION		
ADMINISTRATOR OF VETERANS AFFAIRS:		
Max Cleland	Mar. 1977	Present
Richard L. Roudebush	Oct. 1974	Mar. 1977
Richard L. Roudebush (acting)	Sept. 1974	Oct. 1974
CHIEF MEDICAL DIRECTOR:		
John D. Chase, M.D.	Apr. 1974	Present

(10185)

August 19, 1980.

Hon. **Abraham Ribicoff,**
Chairman, Committee on Governmental Affairs,
U.S. Senate, Washington, D.C.

Dear Mr. Chairman: This is in reponse to your request for the views of this Office on S. 2958, the Federal Interagency Medical Resources Sharing and Coordination Act of 1980. The bill is intended to ensure coordination among Federal agencies in the use of medical resources and greater interagency sharing between the Veterans Administration and the Department of Defense of medical facilities and resources.

We strongly support the objectives of S. 2958, but recommend that certain modifications be made in the bill. Our specific comments are provided below.

One. We believe that this bill should extend to all Federal health care providers, not just to the Department of Defense and the Veterans Administration. Accordingly, we recommend that S. 2958 be amended to include Department of Health and Human Services facilities, or that the legislative history make clear that participation by HHS is not intended to be precluded.

Two. Sec. 3(5). We believe that the definition of "negotiated cost" is a complex issue. At a minimum, the definition of negotiated costs should identify for local hospital officials the principal cost elements to be included. Alternatively, the Federal Interagency Health Resources Committee could be charged with developing such guidelines.

Three. Sec. 4(a). Since a Federal Health Resources Sharing Committee already exists, which includes HHS, we suggest that the language of this provision be changed to identify the existing committee.

Four. Sec. 4(a)(6). We recommend that the guidelines required to be prescribed by the Interagency Committee be subject to ratification by each of the agency heads involved and that this section should so specify.

Five. Sec. 4(a)(6)(F). We are concerned that this provision might be interpreted as requiring the earmarking of collections down to the level of specific units within a sharing facility. Such a requirement is unnecessary and would be administratively burdensome. Accordingly, we suggest that the language be amended to read: "Amounts collected shall be distributed to the facility that generated the reimbursement."

Further, we believe that the provision making collections available for obligation in the year following the year in which the service was provided will create tremendous accounting burdens, and would require, in many instances, the establishment of separate Treasury accounts to separate these funds from the one-year appropriation from which most, if not all, medical actions are funded. We realize that this provision is intended to insure that there would be time for the sharing facility to obligate reimbursements received late in the fiscal year, but believe that end-of-year reimbursement problems can be eliminated through cooperative efforts of the sharing parties.

Six. Sec. 4(a)(6)(G). We believe that a central review and approval by each agency's headquarters is necessary for efficient management of resources; consideration of the current and future impact not only on the local facility, but on thye health care system as a whole; and ensuring compliance with established standards and regulations. It is our understanding that delays experienced in the past have been minimized and that the average time for VA approval of sharing agreements is 20 days. Therefore, we suggest that this provision be revised to read: "Sharing arrangements shall be operative upon review and approval by each agency headquarters."

Seven. Sec. 4(c). We strongly object to this provision, which would permit agencies to request additional personnel and funds from the Congress in order to treat beneficiaries of other providing agencies. This would circumvent the President's administrative authority, and have the effect of eliminating personnel ceilings as a management tool to control Federal employment. We believe that personnel ceiling relief should be sought in the context of executive control over Federal employment, and that necessary funds should flow from the negotiated reimbursement agreement.

Eight. Sec. 4(d). We recommend that the reporting provision make clear that only one report is to be prepared by each agency engaged in interagency sharing, and that this report would be forwarded by the agency to each of the Committees listed.

Subject to the changes noted above, we would favor enactment of S. 2958.

Sincerely,

James M. Frey,
Assistant Director for Legislative Reference, OMB.

HARVARD MEDICAL SCHOOL

RICHARD M. RYAN, JR., D.Sc.
Associate Dean for Medical Services

25 Shattuck Street
Boston, Massachusetts 02115
(617) 732-1543 / 1544

July 21, 1980

The Honorable Charles H. Percy
United States Senate
Washington D.C. 20510

Dear Senator Percy:

While I will not be able to personally testify on behalf of the Federal Interagency Health Resource Sharing and Cooperation Act of 1980, S2613, I wish to comment on this important legislative initiative:

As a former Medical District Director in the Veterans Administration in Medical District One, I was priviledged to grapple with Uniform Service V.A. sharing and patient care issues first hand in the mid nineteen seventies. Despite the highest of motives and dedicated persuit of cooperation, it was extremely difficult for Federal health care professionals to overcome bureaucratic barriers at the national level. One brief but tragic example may help to illustrate my point:

> In 1976 Admiral Harry Allen, of the U.S. Coast Guard who was then the regional Medical Director for the Uniform Services in New England, asked me to assist in caring for an active duty military patient who was suicidal and needed confinement until he could be transferred to an appropriate facilty. Arrangements were made to admit the patient to a V.A. hospital. I was relieved that evening when I spoke with the Chief of Staff of that hospital to find that the serviceman had been cleared for admission to an acute care psychiatric bed. To my absolute dismay, I received a call the next morning indicating that the young man was permitted to discharge himself because a V.A. resident did not believe the V.A. had authority to hold a serviceman who was "admitted against his will." The patient was released and tragically committed suicide! Subsequent meetings worked out acceptable arrangements but the best of arrangments were subject to personal working relationships and good faith. Outstanding problems still persist.

During thoses years, there was no mandate for conjoint planning and sharing of medical resources between the V.A. and D.O.D. Despite the fact that my hospitals had the capacity to provide the highest quality tertiary care to servicemen and selected dependents, the Uniform Services had to turn to private providers or to overburdened specialty services in Philadelphia or Washington. Conversely, veterans requiring care in remote areas distant from the V.A. could not access the Department of Defense Health System. Sophisticated technology available to one or the other system was limited in its accessability by other federal beneficiaries.

The V.A. and Department of Defense Health Systems provide complimenting national systems of care which have the potential for meeting both the separate and combined missions mandated by the Congress to provide the highest quality of care for active duty, retired and dependent beneficiaries of the military and both service connected and non service connected veterans. However, in times which are challenged by runaway inflation and growing demand, the confounding variables of inflation and high cost technology demand maximum cooperation and sharing in order to control runaway costs.

The Conjoint roles of the V.A. and Department of Defense require the most demanding attention to defining these systems and to providing resources to operate efficiently and efficaciously.

The Maximus Report, prepared for the Department of Defense and published on December 5, 1979, reported that (Pg 11) the Armed Services Health systems will not have the capability to care for their own in time of limited war and that whatever capability does exist within its facilities will be required to treat patients who can be returned promptly to duty. This report projects a 20,000 bed need within the V.A. health system.

Your bill, Senator Percy, couldn't come at a more opportune time to examine the conjoint needs of these systems and to define opportunities for interagency sharing. Unless Federal interagency health care policies and procedures for planning, sharing and the provision of health care services are achieved, a vital national resource, the Federal Health care delivery systems, will disappear.

Health Care programs and medical institutions in the United States have thrived on program excellence well founded in biomedical research and training, high technology and humane services. Cost benefit analyses which do not consider the qualitative aspects and indirect benefits of these federal systems may result in first instance dollar savings but will eventually lead to massive expenditures in times of national emergency.

Your bill, Mr. Senator, provides an opportunity to examine the role of Federal Health Care Systems in the National Economy and to achieve effective collaboration in meeting their separate and conjoint purposes.

It is my hope that the tragedies of beneficiary exclusions from care experienced in the past, as well as the tragedies of federal facilities located side by side but not sharing meaningfully across the board will, because of your bill S2613, not be repeated. This bill should begin with the V.A. Department of Medicine and the Defense Health Care Systems. Its success should be measured and, if appropriate, selectively extended to other Federal Health Providers.

I believe S2613 to be landmark legislation from which the flexibility to build opportunities for planning, sharing and collaboration in the Federal sector will provide both maximum economy and improved health services to military and veteran beneficiaries.

Congratulations, S 2613, The Federal Interagency Health Resource Sharing and Cooperation Act of 1980, is an excellent bill.

Sincerely,

Richard M. Ryan, Jr.
Associate Dean
Harvard Medical School

DAV

Motto: "If I cannot speak good of my comrade, I will not speak ill of him."

DISABLED AMERICAN VETERANS

NATIONAL SERVICE and LEGISLATIVE HEADQUARTERS
807 MAINE AVENUE, S.W.
WASHINGTON, D.C. 20024
(202) 554-3501

July 15, 1980

Honorable Charles Percy
United States Senate
Washington, D.C. 20510

Dear Senator Percy:

This letter is written in reference to S. 2613, the Federal Interagency Medical Resources Sharing and Coordination Act of 1980, which was introduced in the Senate by you on April 24, 1980.

As you may be aware, the Disabled American Veterans recently met with Mr. Alan Mertz, a Professional Staff Member (Minority side) of the Senate Committee on Governmental Affairs in discussion of S. 2613.

As the bill title implies, the purpose of S. 2613 is to encourage interagency cooperation in the efficient and effective use of federal medical resources.

Insofar as this goal applies to the health care system of the Veterans Administration, our organization does feel that a broader and more comprehensive sharing arrangement may very well be desirable between the VA and medical facilities under the jurisdiction of the Department of Defense. We especially believe that consideration of such a VA/DOD health care sharing arrangement is worthwhile in terms of enacting a statutorily defined relationship for implementation in time of national emergency and/or period of war.

Of course, the mission of the VA--being the sole, primary federal provider of medical care and treatment to our nation's veteran population--would have to be scrupulously preserved in the event such legislation should be enacted. This especially applies to protecting the quality and extent of care that is now afforded by the VA to America's service-connected veteran population. Your measure, S. 2613, certainly appears to be an appropriate legislative vehicle with regard to the above.

However, notwithstanding the admitted attractiveness of an expanded VA/DOD health care sharing relationship, there is one aspect of S. 2613 which makes the measure totally unacceptable to the DAV--the inclusion of the Department of Health and Human Services amongst the bill's provisions.

Our organization has in the past and shall in the future strongly oppose any administrative or legislative proposal that would extend to the Department of Health and Human Services (formerly HEW) any type of policy making/procedural role relative to the delivery of veterans health care benefits and services.

Without going into great detail, it should be pointed out that HHS, unlike the VA and the military, does not operate a comprehensive, nationwide system of medical facilities that provide direct health care services to a significantly large group of consumers (the seven Public Health Service Hospitals notwithstanding). In our opinion, HHS would have little to offer (to the VA and military) in terms of "sharing" health care facilities.

Also, the Medicare/Medicaid "track record" of HHS leaves much to be desired, vis-a-vis efficient and responsible management of federal health care funds. We see no valid reason to give HHS the opportunity to "practice their art" in the VA health care system.

Lastly, we find absolutely abhorrent the prospect that HHS might have a substantial role in matters that determine the mission and future expansion of our VA hospital system. At best, that agency is indifferent to the special health care needs of veterans; at worst, it is blatantly antagonistic. We do not believe HHS should be given one iota of influence in any program of the Veterans Administration.

I hope these views will be of assistance to you as you move forward on S. 2613. As indicated above, these sentiments have already been conveyed to the Governmental Affairs Committee.

May I say that we deeply appreciate the fact that you have sought our opinion on this most important subject.

Sincerely,

JOHN F. HEILMAN
National Legislative Director

JFH:dlw
cc: Honorable Ray Roberts
Alan Mertz

DAV

Motto: "If I cannot speak good of my comrade, I will not speak ill of him."

DISABLED AMERICAN VETERANS

NATIONAL SERVICE and LEGISLATIVE HEADQUARTERS
807 MAINE AVENUE, S.W.
WASHINGTON, D.C. 20024
(202) 554-3501

August 15, 1980

Honorable Charles Percy
United States Senate
Washington, D. C. 20010

Dear Senator Percy:

This is in reference to your letter dated August 4, 1980, wherein you request the views of the Disabled American Veterans on S. 2958, the Federal Interagency Medical Resources Sharing and Coordination Act of 1980.

As pointed out in your letter, S. 2958 represents a re-draft of S. 2613, a bill that was introduced by you on April 24, 1980.

You may recall that the undersigned, during a meeting with Mr. Alan Merts of your staff and in a letter to you dated July 15, 1980, expressed general support for the basic concept of a statutorily defined health care sharing relationship between the Veterans Administration and the Department of Defense. However, on behalf of the DAV, I also expressed a strong negative reaction concerning the inclusion of the Department of Health and Human Services in any type of health care sharing arrangement with the Veterans Administration (as was specified in S. 2613).

I have reviewed the more recent bill S. 2958 and agree with your statement that "...some of your suggestions were incorporated into the legislation."

The DAV is most pleased and gratified by your decision to delete all references to the Department of Health and Human Services that were contained in the original legislation (S. 2613). By so doing, I assume that you concur with our Organization's assessment that HHS, since it does not operate a comprehensive, nationwide system of medical facilities that provide direct health care services to a significantly large group of consumers, would have little to offer (to the VA and the military) in terms of promoting the efficient use and sharing of federal health care facilities.

The DAV also appreciates the language contained in Section 2(a)(2), Section 4(a)(3) and Section 4(a)(6)(D) which states that no VA/DOD sharing arrangements shall adversely affect the quality and established priority of care provided to an agency's primary beneficiaries.

Therefore, with the exclusion of HHS and the specific inclusion of language that protects and preserves the primary mission of the VA hospital system, the DAV views S. 2958 as an acceptable and desirable legislative vehicle designed to promote a more comprehensive health care sharing arrangement between medical facilities under the jurisdiction of the Veterans Administration and the Department of Defense.

Notwithstanding this basic endorsement of S. 2958, we would like to offer the following suggestions and recommendations:

1) Taking note of the superior position of VA medical care vis-a-vis medical facilities in the Department of Defense, and recalling that during the Vietnam War the Veterans Administration assumed a major role in the care and treatment of medically evacuated battle casualties, we believe it entirely appropriate and desirable that the pending legislation, in addition to addressing the "normal" day to day sharing of VA/DOD health care facilities, include language that would statutorily define the special relationship that should exist between these two agencies during a period of war or other national emergency. The value of such a ready response on the part of the VA is obvious to promoting a sound posture of national defense for our country.

2) With reference to the Federal Interagency Health Resources Committee proposed by Section 4(a) of the bill, we do agree that policy decisions and recommendations should originate from the offices of the VA Administrator and the Secretary of Defense. However, for efficient implementation of such policies and recommendations, we believe that the Committee membership should be expanded (at a "working" level) to include the VA's Chief Medical Director and the Surgeons General of the various branches of the uniformed services.

Honorable Charles Percy
August 15, 1980
Page 3

3) We do not believe it wise to authorize individual VA hospital Directors and commanding officers of military medical facilities to enter into cooperative sharing arrangements among themselves (Section 4(a)(6)(A) of the bill). We believe more centralization is needed here to avoid conflicting and inefficient policies that may tend to arise throughout the country. We recommend language insuring a greater degree of control over facility sharing arrangements by the VA's Chief Medical Director and the Military's Surgeons General.

4) Finally, we note the requirement in Section 4(d) of the bill that requires the Veterans Administration and the Department of Defense to report annually to appropriate Congressional committees of the Congress on various aspects of the VA/DOD health care sharing arrangements. To assure that the Congress receives ongoing information on a more timely basis, we recommend that the Federal Interagency Health Resources Committee (as expanded per our recommendation #2 above) report semiannually to the same Committees of the Congress relative to its responsibilities and actions.

I trust the above comments will receive your careful consideration and provide assistance to you and the Governmental Affairs Committee as you deliberate on this legislation. Thank you again for soliciting the views of the DAV on this most important subject.

Sincerely yours,

JOHN F. HEILMAN
National Legislative Director

JFH:lrd

cc: Mr. Mertz

PARALYZED
VETERANS
OF
AMERICA

CHARTERED BY THE CONGRESS OF THE UNITED STATES

August 15, 1980

Honorable Charles H. Percy
United States Senate
4321 Dirksen Senate Office Building
Washington, D.C. 20510

Dear Senator Percy:

On behalf of Paralyzed Veterans of America, it is a pleasure to respond to your request for comments on S. 2958, the proposed "Federal Interagency Medical Resources Sharing and Coordination Act of 1980." PVA is a veterans' service organization of approximately 11,000 members, all of whom have experienced spinal cord injury or disease. The continued efficacy of health care services to eligible veterans by the Veterans Administration has been the primary concern of our organization since its inception.

The concept of precluding duplication of services and facilities in a specific geographic area is a most worthwhile endeavor. While present and anticipated budgetary pressures may seem to call for reducing redundant services throughout the federal government, it must be noted that any program that would facilitate the sharing and coordination of federal health care facilities and services must ensure that veterans continue to be eligible for health care provided by the Veterans Administration and that no reduction in eligibility take place.

Any attempt to establish sharing and coordinating agreements must be based on existing relationships. It would be inappropriate and injudicious for broad, across-the-board interagency agreements to open specific federal health care facilities to widely divergent, dissimilar client populations. Such interagency agreements would result in the formation of a highly bureaucratic, undifferentiated system of national health care wherein each of the component elements would lose their individual identities. As a result, they would cease to serve the specific needs of their original client populations.

The agencies specified in S. 2958, the Veterans Administration and the Department of Defense, already maintain a policy that would be conducive to the development of an interagency agreement. This understanding requires that the health care system of the Veterans Administration will serve as a backup for the Department of Defense in times of national emergency. The possibility of such emergencies

4350 East-West Highway, Suite 900, Washington, D.C. 20014 (301) 652-2135

must be included in any consideration of the optimum level of available beds and personnel within the VA health care system.

In reviewing S. 2958 it becomes obvious that specific language changes are required if the relationship between the VA and DOD is to be established by interagency agreement and the individuals now served by these two health care systems are to be protected from reduced eligibility and quality of health care.

To set forth PVA's position regarding this concept, Section (2)(1) implies that VA health care facilities are being underutilized and that S. 2958 is designed to correct such underutilization. The VA health care system is not underutilized and has failed to meet the needs of currently eligible veterans. A recent example of this situation occurred with the influx of Cuban refugees. Eligible veterans were denied health care in Florida VA facilities. This occurred because the number of available beds to serve veterans was inadequate, and a few refugees who needed immediate health care treatment disrupted the system.

To ensure that only facilities of the Veterans Administration and the Department of Defense are to be addressed by this legislative proposal, it is necessary that these two agencies be specified by name throughout the bill. Specifically, facilities of the VA and DOD need to be enumerated in Section 3(1) in lieu of "in a facility operated by the United States Government."

Section 3(5), which provides for "negotiated cost" established on a "hospital-by-hospital basis," would allow for a wide range of varying charges. Additionally, with local hospital officials being given such prerogatives, varying services and facilities could be shared in one area, but not in another. This situation would lead to confusion and fragmentation. Based on our members' experience with VA operations, it very likely would prove detrimental to the intent of the bill. It would be much more beneficial to establish a uniform policy for costs. This would reduce the burden of collection and assist in the creation of a uniform system of sharing and coordination.

Section 4(a) establishes a Committee composed of only two individuals, the Secretary of Defense and the Administrator of Veterans' Affairs. This Committee needs to be expanded to include the Chief of the Department of Medicine and Surgery of the Veterans Administration and his DOD counterpart, if the Committee is to deal with sharing and coordinating of health care facilities. It would also be most beneficial to include representatives of health care consumers on this Committee. Representatives from veterans' service organizations, and military service organizations, could provide added insights and serve as a check on potential abuses or actions not in the best interest of the client population.

Honorable Charles H. Percy
August 15, 1980
Page 3

The need for this expanded Committee is indicated by recent attempts by the Office of Management and Budget to thwart the intent of Congress. To have a Committee comprised of only two presidential appointees is to invite further attempts by OMB to use interagency sharing as a means of unnecessarily, arbitrarily, and capriciously reducing federal expenditures, and further cutting needed health care services and facilities.

Our concern for actions on the part of OMB are neither unfounded nor idle speculation. During the past several months OMB has disdained the intent of Congress in matters relating directly to the VA's provision of quality health care for America's veterans. Enclosed are two letters stating PVA's concerns regarding actions by OMB.

As we have indicated, PVA is concerned that the intent of S. 2958 will be misconstrued or purposely misinterpreted to the detriment of the VA health care system. We agree with the general concept of S. 2958, because there exists a need for an interagency sharing and coordinating agreement. But, such an agreement must be made only between the VA and DOD. Safeguards need to be included in any legislative proposal so as to ensure that eligible veterans will continue to receive quality health care and that the integrity of the VA is maintained.

On behalf of the members of Paralyzed Veterans of America and all veterans, I appreciate this opportunity to examine and comment on the provisions of S. 2958.

Sincerely yours,

George A. Conn

George A. Conn
National Legislative Director

Enclosures

best copy available

PARALYZED
VETERANS
OF
AMERICA

April 1, 1980

Honorable James T. McIntyre
Director
Office of Management and Budget
Executive Office Building
Washington, D.C. 20503

Dear Mr. McIntyre:

Paralyzed Veterans of America would like to express its concern with the Office of Management and Budget's designing guidelines by which the Veterans Administration is to implement legislation. I refer specifically to OMB's response to the VA's Department of Medicine and Surgery that a restrictive interpretation is to be applied by DM&S in its furnishing of nonprescription drugs, medicines, and supplies to disabled veterans. Such a regulation, externally imposed by the Office of Management and Budget, would clearly defy the intent of Congress as stated in Title 38, United States Code.

The Report on H.R. 3892, which was later incorporated into the Veterans Health Programs Extension and Improvement Act of 1979 (P.L. 96-151), recommended a system-wide guideline for establishing reasonable limitations for the provision of such items as called for in Section 601(6)(A)(i) of Title 38. This recommendation addressed the need for consistency within the Department of Medicine and Surgery, but it did not mandate further reductions in health care services that are to be provided to veterans.

This section of Title 38 clearly states that the VA Administrator is to determine when the issuing of these items is "reasonable and necessary," but OMB plans to require the Department of Medicine and Surgery to curtail this service to veterans, thereby saving the government $10,000,000. The Department of Medicine and Surgery is already operating with an inadequate budget and is acutely cost-conscious, but it fully recognizes that denying veterans necessary supplies is not a suitable means of reducing expenditures.

The Office of Management and Budget has consistently attempted to reduce health care services that are available to veterans through the VA. In its plan to require the Department of Medicine and Surgery to curtail its providing of nonprescription drugs, medicines and supplies, OMB furnishes another example of its attack on veterans' benefits and of its disregard for Congressional intent.

PVA requests that OMB give additional consideration to this matter and allow the Veterans Administration to implement this and other provisions of Title 38 as intended by the Congress.

Thank you for your time and consideration.

Sincerely yours,

Earl Kelly

Earl Kelly
Acting Legislative Director

cc: Honorable Alan Cranston
Honorable Ray Roberts
Honorable Max Cleland
Dr. Donald Custis

PARALYZED
VETERANS
OF
AMERICA

July 15, 1980

Mr. Lynn Etheredge, Chief
Health Branch
Office of Management and Budget
Room 7002, NEOB
726 Jackson Place, N.W.
Washington, D.C. 20503

Dear Mr. Etheredge:

In accordance with the Federal Register of June 17, 1980, Paralyzed Veterans of America would like to offer its comments concerning the proposed memorandum, "Federal Support for Hospital Construction in Overbedded Areas." We foresee several significant problems inherent in this proposal, specifically as it affects the Veterans Administration health care system.

First, the VA health care system differs from local health care facilities as it is a federal system dedicated to serving the needs of the nation's veterans. In addition, it serves as a back-up system to the Department of Defense in times of national emergency or military involvement. While it may be assumed in some quarters that an excess number of hospital beds unnecessarily adds to the cost of health care, it is injudicious to allow specific local conditions to dictate the establishment of VA health care facilities. Any given VA hospital is part of a comprehensive network that serves veterans from a wide geographic area. In fact, such cachement areas are much larger than the local community in which the facility is actually located. It would be defeating the very purpose of this national system of health care if local authorities, policy determination factors and conditions controlled the size, scope and function of any VA medical center.

It must be noted that OMB Circular A-95 already required the VA to submit project proposals to local Health Systems Agencies when the VA seeks to construct, or significantly modify VA hospitals. These non-binding appraisals by HSAs are considered by OMB which uses them for budget considerations before the VA is allowed to proceed with implementing its request for funding of a given project. Furthermore, the VA must have OMB's approval, which is based on the HSAs' evaluations and other considerations, before it can even present its budget request to Congress.

Second, the VA health care system is controlled by the Veterans Administration under the guidance and control of Congressional action as expressed in Title 38, United States Code. Sections 5002, 5003, and 5004 of Title 38 clearly state the procedures to be employed when the VA seeks to establish, or alter, health care facilities. Section 5004 aims to "ensure the equitable distribution of medical facilities throughout the United States, taking into consideration the comparative urgency of the need for the services to be provided in the case of each particular facility." It itemizes the very reasonable criteria to be employed by the Administrator and allows him considerable discretion when establishing health care facilities. Specifically, in case of construction, no action can be taken until "each (congressional) committee has first adopted a resolution approving such construction," and in the case of leasing, "no appropriation may be made for the average annual rental of more than $500,000 unless each committee has first adopted a resolution approving such lease and setting forth the estimated cost thereof." Sections 5002, 5003, and 5004 of Title 38, United States Code, are attached to this letter.

Third, the Veterans Administration is a separate, and independent, federal agency designed to provide a wide variety of unique, valuable services to eligible veterans, including health care services. No other federal agency has this responsibility assigned to it. No other federal agency must answer to the Senate and House Committees on Veterans' Affairs in the same manner as the Veterans Administration.

The proposal under consideration not only would subject construction of VA hospitals to local authorities, but would additionally place this VA function ultimately under the control of the Secretary of Health and Human Services: "Alternative standards for determining whether a Health Service Area is overbedded may be established by a State Health Planning and Development Agency, subject to approval by the Secretary of Health and Human Services." (Page 41098, Federal Register of June 17, 1980). Implementation of the proposed policy would undermine much of the VA Administrator's authority to direct the functions of his agency as mandated by law.

In addition to weakening the autonomy of the VA, such a policy would actually increase the cost of VA health care. The VA would have to survey each HSA involved. Currently, the VA has only to submit the proposal to HSAs, which have the opportunity of responding. If this new policy is implemented, the VA would have to actively solicit these responses.

Large urban centers are appropriate locations for VA hospitals because of veteran population density, the potential for creating jobs for disabled veterans and persons with low incomes, and the availability of transportation systems. Such areas encompass other jurisdictions, and HSAs, all of which would have to be consulted before VA construction could proceed. Local and county governments historically put their interests above the needs of other areas. Thus, we foresee VA facilities becoming a source of contention for adjoining jurisdictions. Therefore, PVA envisions senseless delays in needed construction projects, resulting in fiscal waste due to the constantly rising cost of construction.

Paragraph 6(4) of the Federal Register notice states: "The policies established by this Memorandum apply to all facilities for which construction funds have not been obligated as of the effective date of this Memorandum...." In cases where OMB has approved such projects and Congress has appropriated funds, considerable problems will arise because the funds have not been "obligated." Until the Administrator gets a consensus of agreement from the various HSAs, and is granted approval by the Department of Health and Human Services, no construction contract could be made. Funds are "obligated" only when the contract is let, and the delays in pending projects would make them considerably more expensive, with construction costs increasing approximately 12 percent annually.

A final inflationary result of the proposals contained in the "Federal Support for Hospital Construction in Overbedded Areas" would come from the increased size of managerial staff the VA would require, and the additional burdens placed on it to direct a potentially dispersed health care system. For example, to say that a particular city has a certain number of excess hospital beds does not mean that those beds are located near a central facility, or in that facility. Certainly, the administrative and medical management aspects of such a situation would be compounded, rather than enhanced. The policy frequently speaks of "Suitable" non-federal facilities, but never defines the term. Hence, we foresee the VA, and other federal hospital systems, being burdened with attempting to manage a variety of rented spaces over a vast geographic area.

Purchasing non-VA facilities is likely to be less cost effective than renting them because of the nature of structures that would be purchaseable. Over the years, the acquisition of older structures can easily exceed any recognized savings due to accelerating maintenance and repair costs. Furthermore, these excess older facilities are quite likely to be located in crowded, undesirable areas and will lack accessibility features for totally disabled veterans. They certainly will not offer the well-planned, longer solution to veterans' health care needs that newer facilities provide.

VA must point out that we share the Administration's concern for escalating hospital costs in civilian centers. We, too, want to see this curtailed. However, we do not feel that attempts to terminate the VA health care system's separate existence will reduce the rising costs of health care. The VA provides treatment more inexpensively than do civilian hospitals, especially in critical areas such as spinal cord injury care.

The Veterans Administration has not produced the excess number of hospital beds that exist in the nation today. A decade ago there were 27,647,000 veterans in the nation and 102,633 hospital beds to meet their health care needs. Today the number of veterans has risen to 30,000,000 but the number of hospital beds has decreased to 84,351. The VA is, largely out of fiscal restraint, producing a shorter hospital stay per patient than is the private sector.

PVA has reviewed statistical reports of increasing hospitalization costs because of the unnecessary duration of patient visits, but it is likely that the hospitals themselves contribute to this waste in an effort to make use of existing bed space. In short, health care programs (other than the VA) in conjunction with local health care planners, have created an excess of hospital beds. As a result, the Veterans Administration health care system is being sacrificed to save these local economic ventures. Thus veterans, especially those who became totally, and permanently, disabled as a result of service to the nation, and whom the tax-paying public willingly supports, are arbitrarily threatened by mismanagement by the federal government and the private medical sector with the loss of a medical system to which they are statutorily entitled.

As mentioned earlier, Congress and the Administration direct and control the functions of the VA medical system. This national program of health care must not be administratively influenced by local, non-elected planning bodies. Furthermore, the Veterans Administration must remain an autonomous federal agency if it is to serve the needs of the nation's veterans. Implementation of the policies and procedures outlined above would virtually destroy the scope of the VA health care system, and would do much to undermine the autonomy of the Veterans Administration.

On behalf of the members of Paralyzed Veterans of America and all veterans, I appreciate this opportunity to examine the Administrations policy and procedures.

Sincerely,

George Conn

George A. Conn
National Legislative Director

Attachment

cc: Senator Cranston
Congressman Roberts
Mr. Cleland - VA Administrator
Dr. Custis - Chief Medical Director - VA

GAC/ef

THE AMERICAN LEGION
1608 K STREET, N. W.
WASHINGTON, D. C. 20006

July 16, 1980

Honorable Charles H. Percy
United States Senate
4321 Dirksen Senate Office Bldg.
Washington, DC 20510

ATTN: Alan Mertz

Dear Senator Percy:

This letter is in response to a request for a written communication from The American Legion on the subject of S. 2613, made during a conference with Alan Mertz of your staff on July 11, 1980.

As this letter is prepared we have at hand copy of S. 2613, copy of a re-draft of the bill, and copy of the Comptroller General's Report to the Congress dated June 14, 1978 and titled Legislation Needed to Encourage Better Use of Federal Medical Resources And Remove Obstacles to Interagency Sharing.

Let us say at the outset that The American Legion desires to pursue a positive attitude to the concept of sharing Federal Medical Resources where feasible. We are already supportive of the fact that the Veterans Administration is and must be a national security resource, available to the Department of Defense in case of a military emergency that resulted in casualties that would require medical care beyond the immediate capabilities of the Armed Forces health care facilities.

It is also true, however, that The American Legion, in line with the purposes and goals for which it was organized, cannot for a moment lose sight of the primary goal of the Veterans Administration health care delivery system. That goal is to provide timely, top quality care to the service disabled, and beyond that to provide timely, top quality care to all veterans who by law are entitled to apply for and receive such care. The American Legion cannot and will not acquiesce to any program of sharing that will interfere with the attainment of this objective by VA.

While, at first glance, the concept of sharing medical resources is an attractive one, in the interest of economy of government, upon close examination it is not an easy concept of implementation, given the unique missions of the various agencies of Government that possess health care capabilities. The goal of VA we have defined above. The responsibility of DOD is to maintain a force fit to fight in defense of the national interest. The Department of Health and Human Services has a multifarious series of responsibilities to provide for the national health and welfare. The uniqueness of these responsibilities does not lend itself to an easily arranged sharing of any substantial measure.

In fact, the responsibilities of HHS are so diverse that, in our judgment the officials of that department have no perspective that would enable them to understand or share in the goals of VA. Therefore, we are categorically opposed to any substantial sharing arrangement that would include a degree of participation by HHS in the responsibility for the health care goals of VA.

From our viewpoint, that brings us down to the question of sharing as between DOD and VA. Here again, the uniqueness of the mission of each agency complicates any effort to develop a substantial sharing arrangement.

For example, VA maintains, within its 172 medical center entity, a series of tertiary hospitals that are required to provide a full range of medical services to seriously ill patients - including the most sophisticated diagnostic and treatment modalities that medical science has so far developed. This fundamental responsibility to its legally eligible clientele means that its resources must be totally available at all times. Also to be considered in this context are the geographical locations of the various hospitals and clinics, their size and their configuration, all of which are designed to facilitate the accomplishment of their primary goal. The Legion is also concerned about the provision of resources to another agency by VA that would result in those resources not being available when needed for treatment of legally eligible veterans. Here we get into a question of priorities. It has been our experience that in peacetime, there is a tendency by agencies other than VA to place veterans in a lower class of priority than other deserving classes of beneficiaries. Such an eventuality is totally unacceptable to The American Legion.

The zeal to reduce hospital costs has brought into question many if not most of the costs and charges for the sophisticated equipment that is part of modern health care delivery. CAT Scanners are a prime example. It is a commonly expressed belief that because the cost of these units ranges upward to $700,000, they should not be duplicated in hospitals within a commuting area. There are other factors involved, however, that are not considered by those who simply look at dollar signs, without any understanding of the delivery of health care to sick persons. For example, often those for whom the CAT Scanner diagnostic procedure is most needed are those least able to be safely moved, such as patients with head injuries. It must also be expected that the institution providing the service will schedule its own patients first - possibly leaving critical patients in care of the sharer dangerously waiting for completion of the procedure.

Then there is the matter of the cost of ambulance transportation, which becomes a significant factor when such cost ranges to $100 for a round trip, within a commuting area.

Another factor in the operation of tertiary hospitals is the difficulty in attracting and retaining a competent staff in today's competitive market. Highly skilled professionals will not work where they cannot follow their patients to final disposition. And, in acquiring, and retaining high quality professionals, it is necessary to have the complete team. For example, a hospital cannot undertake cardiac catheterization unless a cardiac surgeon is available. In case of an accident during the procedure, surgery is an immediate necessity at risk of life.

From these examples we intend to demonstrate that in the case of tertiary hospitals, total capability for patient care is a necessity. Which fact does not preclude sharing, as between a VA and a university hospital, especially where they are adjacent.

And this lends itself to the worthwhile approach in the draft legislation to leave the accomplishment of the sharing agreement to be completed at the institution level, rather than centrally.

We also believe the proposed committee to promote sharing among Federal institutions is composed of officers at a level too high to be practical in achieving the desired goal. It would be preferable, in our judgment, to establish the committee at the level of Surgeon General and Chief Medical Director. These officers would be more immediately effective in developing practical sharing arrangements, and in supervising the implementation of such arrangements.

Where the locale and the availability of resources is such that sharing seems clearly feasible, it has been stated that the ability to negotiate sharing contracts has not been accomplished for a variety of not always clearly defined reasons. We do not find this obstacle to a sharing arrangement compelling. VA has had a contractual relationship with the Army and Air Force in both Alaska and Hawaii for a considerable period of time. Given mutual good-will, and clearly defined and enforced objectives set by competent authority, we see no reason why similar arrangements cannot be accomplished at other places.

An integral element of the comprehensive medical care provided by VA today is the affiliation with medical schools. The affiliation program has changed, and significantly improved the quality of care provided by VA. This element of the VA system should, in our judgment, be acknowledged in any legislation affecting the sharing of Federal medical resources. Patients in military hospitals could thus share in the benefits that derive to veteran patients through the affiliation program.

In any sharing arrangement that is set in place, there arises the matter of reimbursement. One of the objections to legislation would be hopefully eliminated by providing for station to station reimbursement. This possibility does not entirely satisfy our apprehensions on this point, by reason of the fact that in our view, nothing would prevent the Office of Management and Budget from adjusting agency funding to compensate for station to station sharing. This is a real danger since we are having chronic difficulties securing full funding for veterans programs through unsympathetic attitudes prevailing to a lesser extent in Congress and a greater extent at OMB.

In the legislative arena, we are wary of allowing Committees of Congress other than the Veterans Affairs Committees to acquire any measure of responsibility for the operations of VA. Our experience has been that other Committees do not understand nor share the concern for veterans and their problems that we look for and find in the Veterans Affairs Committees.

With these impressions in mind, we now raise the point of whether legislation of the type put forth by S. 2613 is necessary or advisable at this juncture. It would be our preference to use Executive authority to cause VA and DOD to investigate and pursue a course of accommodation to each other's needs on a basis of mutual endeavor, keeping in mind the mission of the two agencies, and motivated by good will toward such missions, and a sincere desire to achieve maximum and optimum utilization of available resources, without interfering with the accomplishment of the respective missions. We would recommend that this approach be tried before the development of complicated, inflexible and potentially confusing legislation be pursued.

We thank you for the opportunity of presenting our views on this important matter.

Sincerely,

R. E. LYNCH, Director
National Veterans Affairs and
Rehabilitation Commission

bcc: Dr. Richard Ryan
Dr. Thomas FitzGerald
Mark Fleming
Jonathan Steinberg
Mylio Kraja
Paul Egan

The American Legion
For God and Country

• WASHINGTON OFFICE • 1608 "K" STREET, N.W. • WASHINGTON, D.C. 20006 •
(202) 861-2700 •

14

August 7, 1980

Honorable Charles H. Percy
United States Senator
4321 Dirksen Senate Office Bldg.
Washington, D. C. 20510

Dear Senator Percy:

Thank you for sending me a copy of S. 2958 as reintroduced on July 23rd.

I believe the comments I submitted to you on July 16, 1980, are still appropriate. With regard to the question Mr. Wertz asked concerning the opinion of The American Legion if the Public Health Service Hospitals were included, I submit the following:

From a legislative standpoint, it is understandable that you would desire to include the PHS Hospitals. This would be acceptable if the level of participation were limited to the Surgeon General of the United States.

Specifically, we believe it would be unacceptable for HHS to be involved at the levels of the Secretary of HHS for the reasons explained in my letter of July 16, 1980. Under no circumstances do we feel that HHS should be involved in the administration of the Veterans Administration or the Department of Defense.

Sincerely,

R. E. Lynch

TJF/ced

R. E. LYNCH, DIRECTOR
National Veterans Affairs
and
Rehabilitation Commission

AMVETS
AMERICAN VETERANS OF WORLD WAR II-KOREA-VIET NAM
NATIONAL HEADQUARTERS
1710 RHODE ISLAND AVENUE, N.W., WASHINGTON, D.C. 20036 (202) [illegible]

GABRIEL P. BRINSKY
NATIONAL SERVICE AND
LEGISLATIVE DIRECTOR

July 28, 1980

Honorable Charles E. Percy
United States Senate
4321 Dirksen Senate Office Building
Washington, D. C. 20510

ATTN: Alan Mertz

Dear Senator Percy:

This is to confirm AMVETS interest in S 2613 which was expressed in a telephonic communication with you.

We agree with the concept that an arrangement between the Veterans Administration and the Department of Defense to share medical facilities is highly desirable. AMVETS has traditionally considered the Veterans Administration Health Care Program as a back-up to the needs of the Department of Defense in time of National emergency or a period of war. It is one of the reasons why we have viewed with particular alarm the reduction of beds in the Veterans Administration hospital system over the past years.

Our objection to S 2613, as originally drafted, was the role assigned to the Department of Health and Human Services which would effect the mission and expansion of Veterans Administration hospital program.

The copy of the mark-up of S 2613, which you furnished, would remedy this undesirable feature by eliminating HHS from the Veterans Administration and Department of Defense co-operative efforts.

Thank you for giving AMVETS the opportunity to express its views.

Very truly yours,

GABRIEL P. BRINSKY
National Service & Legislative Director

"UNITY MAKES FOR PROGRESS"

UNIVERSITY OF HEALTH SCIENCES|THE CHICAGO MEDICAL SCHOOL
2020 West Ogden Avenue Chicago Illinois 60612 (312) [illegible] 942-2810

OFFICE OF THE DEAN
THE CHICAGO MEDICAL SCHOOL

~~JA~~
AM

July 9, 1980

Senator Charles H. Percy
4321 Dirksen Senate Office Building
Room 1200
Washington, D.C. 20510

Dear Senator Percy:

I was pleased to see that you have introduced a bill relating to Federal Sharing. I did not know if you are aware of a pertinent related situation in the State of Illinois.

I have spoken independently to the Assistant Secretary for Health in the Department of Defense, Dr. Jack Moxley, the Surgeon General of the Navy, Vice-Admiral W.P. Arentzen, and the Chief Medical Director of the Veterans Administration in Washington, Dr. Donald Custis, late last year regarding sharing services between the North Chicago Veterans Administration Hospital and the United States Naval Hospital located in Great Lakes. (Enclosure #1) Both of these hospitals are major affiliates of the University of Health Sciences/The Chicago Medical School and have been since 1973. My discussion with these gentlemen were related to my position as the Dean of an affiliated medical school.

The North Chicago Veterans Administration Hospital has many physicians which are paid partly by the school and are members of our faculty. Other members of our faculty were spending some time at the Navy helping to relieve the physician shortage at that institution by delivering health services to some of the Navy personnel.

It became apparent to me that the Naval Hospital at Great Lakes was a relatively modern facility with a considerable amount of empty beds, many potential patients, but no physicians. On the other hand, the adjacent North Chicago Veterans Administration Hospital has many physicians, many of whom are on the University faculty who could be available to treat the Navy patients as well as the Veterans, if the appropriate sharing could be arranged. In other words, better patient care and savings of dollars could be accomplished by a sharing of Federal resources catalyzed by a medical school whose campus was contiguous to both institutions. This could be a terrific "pilot program."

UNIVERSITY OF HEALTH SCIENCES | THE CHICAGO MEDICAL SCHOOL
2020 West Ogden Avenue Chicago Illinois 60612

Senator Charles H. Percy
July 9, 1980
page 2.

Following my discussions with the Federal Authorities, a team was appointed by Admiral Ahrenson and Dr. Donald Custis to review the possibility of sharing at these institutions, and perhaps to combine both institutions into one. This team made a Phase I visit last may, and as I understand, are still considering this sharing possibility. The school would be benefited by contributing to better patient care and by an expanded teaching program.

Lurking in the background, prior to your proposed legislation, were the prohibitions to Federal Sharing which I believe would be obviated by your proposed legislation. I have not seen your bill as yet, and I would appreciate your sending me a copy.

Sharing of Federal Health Care Resources could also be expanded to other areas in the private sector for further effectiveness, in the future.

If you feel that I could be of help to you, or if you would like to discuss this, please let me know.

Sincerely yours,

Marshall A. Falk, MD
Dean

MAF:lf
enclosure

Department of Medicine
and Surgery

Washington, D.C. 20420

Veterans
Administration

January 31, 1980

Marshall A. Falk, M.D.
Dean
University of Health Sciences
The Chicago Medical School
Chicago, IL 60612

Dear Dean Falk:

We apparently have a problem of a lost letter which, by reason of no office having a file copy, may well have never been written, in spite of my (memory) of having done so.

I did indeed discuss with Dr. Jack Moxley, Assistant Secretary for Health Affairs, Department of Defense, the possibility of a closer sharing arrangement between the VA Medical Center in North Chicago and the Naval Hospital in Great Lakes. He, in turn, voiced his intention of speaking with Admiral W. P. Arentzen.

The first step in exploring such potential is for local management to develop a proposal for consideration by the respective offices. Mr. James Caldwell, Regional Director, is prepared to participate, along with the VA Medical Center Director at North Chicago, Donald McGee, and Captain R. J. Seeley, Commanding Officer, Navy Regional Medical Center, Great Lakes, working together with your representative.

If I can be of any further assistance, please let me know; otherwise I will await your initiative.

Sincerely,

DONALD L. CUSTIS, M.D.
Chief Medical Director

RECEIVED DIRECT
FEB - 5 1980
THE
CHICAGO MEDICAL SCHOOL
OFFICE OF THE DEAN

In Reply Refer To:

Enclosure #1

December 10, 1979

Donald L. Custis, MD
Deputy Chief Medical Director
Veterans Administration Central Office
Department of Medicine and Surgery
810 Vermont Avenue
Washington, D.C. 20420

Dear Doctor Custis:

This letter is a follow-up on our conversation which took place in your office on October 5, 1979, and a second conversation on the phone on October 6, 1979, at which time I reported to you on a talk I had, at your suggestion, with Assistant Secretary for Health Affairs, Department of Defense, Dr. John Moxley.

As you recall, I asked you about the possibility of a joint arrangement between the Navy and the Veterans Administration whereby the acute medical/surgical operation at the North Chicago Veterans Administration Hospital would be relocated to the Naval Hospital at Great Lakes.

My interest in this is based on the fact that many of the NCVA physicians are jointly employed by UHS/CMS, and participate in the NCVA-UHS/CMS joint teaching programs. In addition to this, the Great Lakes Naval Regional Medical Center is a long-standing affiliate of the medical school.

Further, my proposal is based on the situation in which the Navy has an excess of beds and patients, with a critical shortage of medical personnel. Because of this physician shortage, the Navy has been forced to have its patients treated outside of the Great Lakes facility, at obviously greater expense to the government.

The advantages to the North Chicago Veterans Administration Hospital would be a change in its image to its acute medical/surgical veteran constituency. They would not see the hospital at which they are being treated for a medical or surgical condition as a psychiatric facility. The school and the V.A. have been working hard to change this image for years, but have been only nominally successful. Having access to a newer facility would also be an advantage in the care of veterans.

In a sense, the situation appears to be that the Navy has patients and space, but no physicians. The VAH "across the street" has physicians, many of whom are jointly employed by the V.A. and the school. In our current national fiscal environment, the situation appears to be an anachronism.

The advantage to the medical school and the V.A. would be an enhanced teaching program in a newer facility. In addition, moving the V.A. acute medical and surgical beds to the Navy hospital would help in recruiting competent American physicians because of the new environment.

You suggested that I discuss this with Doctor Moxley. I did this on October 6, and he was receptive to the idea and said he would discuss it with Admiral Arentzen. I reported to you on my conversation with Doctor Moxley on the same day, and I believe you indicated that you also were receptive to the idea, and would discuss it with appropriate individuals.

The purpose of this letter is to respectfully inquire as to the status of the situation.

Sincerely yours,

Marshall A. Falk, MD
Dean

MAF/ob
cc: Capt. Seeley
Mr. McGee

bcc: Mr. Quent

UNIVERSITY OF CALIFORNIA, SAN DIEGO

BERKELEY · DAVIS · IRVINE · LOS ANGELES · RIVERSIDE · SAN DIEGO · SAN FRANCISCO SANTA BARBARA · SANTA CRUZ

DEPARTMENT Radiation Oncology

UNIVERSITY OF CALIFORNIA MEDICAL CENTER
SAN DIEGO
UNIVERSITY HOSPITAL
225 DICKINSON STREET
SAN DIEGO, CALIFORNIA 92103

August 1, 1980

HC
AM

Senator Charles Percy
Senate Office Building
Washington, D.C. 20510

Dear Senator Percy:

A local San Diego paper carried a brief summary of your comments with respect to the potential integration and sharing of services between the Navy and Veterans Administration Hospitals here. There are many of us here who share your concern. The Veterans Administration Hospital here has chronically suffered from a low patient census which in many areas seriously hampers medical student and house officer training. Across the city, the Navy physicians are tremendously overworked. Why there cannot be a coordinated care for patients eligible for federal support is not a bit clear.

It is obvious that the Navy needs a new hospital here. It is equally obvious that the Navy must have facilities capable of caring for an abrupt increase in patients should some form of military action occur. However, there is no obvious reason whatsoever why chronically ill patients or patients who have retired from the Navy need to be cared in the Navy's over-worked facilities.

As a radiation oncologist, I deal exclusively with patients with malignancy. A large number of patients with advanced cancer are also seen at the Naval Hospital. Surely the Navy could release these patients from its care and transfer them as far as possible to the Veterans Administration where they could more appropriately be treated. Both the Veterans Administration and the Navy in their expansion plans wish to install costly radiotherapeutic machinery. This will amount to a duplication of facilities for the specific treatment of patients who by no stretch of the imagination would be involved in active military duty.

I would suggest that the federal government plan to transfer the care of patients with cancer to the Veterans Administration Hospital and at the Veterans Hospital develop a first-class facility involving all aspects of cancer care. Since the Veterans Administration Hospital is in close affiliation with the University of California San Diego Cancer Center, this would allow all of the federal patients to receive optimum care. In addition, it would make available to the medical scientists involved in attempting to improve cancer treatment a large number of patients who might be eligible for clinical trials. This would thereby facilitate the programs with the University Cancer Center that are currently supported by the National Cancer Institute.

I have in the past attempted to interest the administration of these various hospitals in this approach but have not gotten very far. Perhaps some attention from an interested elected official at the national level would facilitate an evaluation of this idea.

Sincerely yours,

John E. Byfield, M.D., Ph.D.
Professor of Radiology & Medicine
Chief, Radiation Oncology

JEB/mbh

cc: Senator Cranston
Senator Hayakawa

C. ALEX ALEXANDER, M. D.
1343 ASHBURTON DRIVE
DAYTON, OHIO 45459
TELEPHONE 434-8959

June 30, 1980

Mr. Alan Mertz
Professional Staff Member
United States Senate
Committee on Governmental Affairs
Washington, D.C. 20510

Dear Mr. Mertz:

I thank you for your letter of June 19th and the attached copy of Senator Percy's Bill S-2613.

I am indeed delighted to see Senator Percy's interest in promoting sharing of medical resources between Federal health facilities. As you may very well know, a strong attempt was made in 1973 to make the Army, Navy and Air Force share medical resources through the regionalization concept. The House Armed Services Committee examined that approach and concluded that it was a mere paper exercise, that no true sharing really occurred. You may be interested in reading the attached editorial I wrote for the Journal of Military Medicine. Therefore, I am not sure that a Federal Interagency Health Resources Committee as envisaged in S-2613 would be sufficient to promote "sharing" between Federal Health Agencies. Perhaps the Congressional oversight combined with GAO's monitoring of this effort may pull it off.

I am pleased to make the following comments on the Bill based on my observations of our sharing experience between the Dayton VA Medical Center and WPAFB Medical Center in Dayton, Ohio:

1. Section 6(f) of the Bill will function as a powerful incentive if you can strengthen it (Line 18-20, Page 6) by providing a mechanism whereby reimbursement to the providing facility can be prompt and take place within a short period of rendering the services, preferably within one year.

2. In my opinion, the Bill should contain a provision for the exchange of medical and other health professional personnel on inter-agency consultant detail upon agreement of the directors and commanding officers. Such details must be voluntary and should be done only with the written consent of the professionals involved. We have had some positive experience in this regard. Our thoracic surgeon has gone many times to the WPAFB Medical Center to provide consultation as well as perform surgery after WPAFB Medical Center's surgeon left last year. In return, we have also used WPAFB Medical Center's nephrologist to keep open our renal dialysis program when we did not have a nephrologist for a short period. Even though we were able to provide such exchange of professionals, it required a great deal of "cajoling" to get these professionals to go across town and perform these "additional" duties. If Senator Percy's Bill will allow some monetary "incentives" by way of providing a mechanism to reimburse these specialists for their travel and

Mr. Alan Mertz
Washington, D.C.

their "consultant" services to another Federal agency, I believe that military medical facilities as well as VA Medical facilities will be able to share the services of scarce medical specialists. In addition to the travel expenses, a small consultant fee per day may be offered to promote "sharing" of such consultant services.

3. I hope that the Bill can also be expanded to permit the directors and commanding officers to adjust their personnel ceiling as and when they can demonstrate (on the basis of a year's sharing experience) that an increase ~~and~~ or decrease of personnel is needed to continue the sharing arrangement.

4. Similarly, the Bill ought to provide the flexibility for directors and commanding officers to utilize the "reimbursements" to purchase equipment as well as undertake minor renovation/construction of existing facilities to accommodate the demands generated by sharing agreements.

Besides the above few points, I have nothing more to add except to say that my comments are offered in my personal capacity and not as the Chief of Staff of the VA Medical Center, Dayton, Ohio. To make that even more explicit, I am sending this note to you on my personal stationery.

Nonetheless, please be assured that I would be happy to answer questions, or offer further comments on the legislation as it progresses. I would be obliged if you will keep me posted of the outcome of S-2613. I can be reached on FTS 774-2255.

I enjoyed chatting with you and kindly convey my deepest appreciation to Senator Percy for his attempt to get the Federal agencies to work together. I sincerely hope that the bill passes with at least some of the necessary incentives built into it. It seems to me that the Federal agencies need a lot more "incentives" than private institutions do!

With best regards.

Yours sincerely,

C. ALEX ALEXANDER, M.D., Dr. P.H.

Encl.

150 South Huntington Avenue
Boston, Massachusetts 02130

SEP 1 5 [illegible]

In reply refer to: 523/134C/11

Regional Director (10BA1/13C)
Northeastern Region
Veterans Administration Central Office
810 Vermont Avenue
Washington, D.C. 20420

SUBJ: Sharing Agreement

In accordance with VAPR 8-1.403-52(a)(2), enclosed are three copies of the proposed sharing agreement for the mutual use of specialized medical resources to be provided by the Veterans Administration to Cutler Army Hospital, Fort Devens, Massachusetts.

CARLTON M. SMITH
Medical Center Director

Encs.

Show veteran's full name, VA file number, and social security number on all correspondence.

Veterans
Administration

DEC 21 1979

Director (00/134)
VA Medical Center
150 South Huntington Avenue
Boston, Massachusetts 02130

SUBJ: Sharing Agreement (Your letter of September 13, 1979)

1. Your request to enter into a Mutual Use Contract with Cutler Army Hospital is approved.

2. The VA furnishes: Orthopedic clinical consultations and Specialized orthopedic surgical procedures (Inpatient and Outpatient) Otolaryngological clinical consultations, and Specialized otolaryngology surgical procedures (Inpatient and Outpatient).

3. Please furnish us with an executed copy of this contract within 15 days after signature by both parties.

Donald B. Thompson
JAMES C. CRUTCHER, M. D.
Chief Medical Director

Enclosure

FROM: MEDICAL CENTER [illegible]
ACTION: 134
INFO: 11
DATE ROUTED: 1/3/80
SUSPENSE:

RECEIVED
[illegible]

JAN 2 1980

In Reply Refer To: 13C

September 12, 1979

323/11

Col. Eugene F. Hyland
Commanding Officer
Cutler Army Hospital
Fort Devens, Massachusetts 01433

Dear Col. Hyland:

As per our telephone conversation of Monday, September 10, 1979, I am enclosing two copies of the current sharing agreement proposal between our two institutions. I am sending three copies of this sharing agreement to Veterans Administration Central Office today. I know that the authorities in Veterans Administration Central Office will bring this agreement up with Veterans Administration legal counsel for their concurrence. Hopefully, this will not take too long.

I believe that General Becker of the Surgeon General's office is in the process of discussing this sharing agreement with your Health Services Command representatives.

Sincerely yours,

LEON J. MARKS, M.D.
Acting Chief of Staff

Encs.

MUTUAL USE OF SPECIALIZED MEDICAL RESOURCES

PROVIDED BY

THE VETERANS ADMINISTRATION MEDICAL CENTER, BOSTON, MASSACHUSETTS

AND

CUTLER ARMY HOSPITAL, FORT DEVENS, MASSACHUSETTS 01433

The Veterans Administration Medical Center, 150 South Huntington Avenue, Boston, Massachusetts, (hereinafter called the VA) agrees, in accordance with the terms and conditions stated herein, to permit the Cutler Army Hospital, Fort Devens, Massachusetts, (hereinafter called the Contractor) to utilize the specialized medical resources listed in the appendixes to this agreement at the prices specified therein for active military personnel at Cutler Army Hospital, Fort Devens, Massachusetts. The initial listing of resources available to the Contractor shall be designated "Appendix A" and each succeeding appendix which either adds or deletes from the resources available to the Contractor shall be designed as "Appendix B", "Appendix C", etc. Each appendix shall be attached to and become a part of this agreement.

1. **RESOURCES.**

a. The resources listed in any of the attached appendixes may be added to or terminated by written amendment to this agreement. The amendment will be prepared by the VA Contracting Officer and, prior to becoming effective, shall be approved by the Chief Medical Director or his authorized designee.

b. The resources specified in the appendixes to this agreement shall be made available to the Contractor subject to the limitations in Paragraph 5 hereof when requested by means of an individual written request which has been authorized by the Contracting Officer or his authorized designee.

2. **PERIOD COVERED.**

This agreement when accepted by the Contractor and the VA Contracting Officer shall be effective from   through September 30, 1980.

3. **TERMINATION.**

This agreement will remain in force for the period stated herein unless terminated at the request of either party after thirty (30) days' notice in writing. If this agreement is so terminated the Contractor shall be liable only for payment for the resources he has used from the date of last service for which he has been billed by the VA, through the effective date of such termination.

4. **PAYMENT.**

Payment of sums due the VA will be paid monthly by the Contractor on submission of a properly prepared Standard Form 1114 by the VA.

5. **USE OF VA RESOURCES.**

To preclude the possibility of denying or delaying the care and treatment of an eligible veterans, VA resources will be used by the Contractor only to the extent that there will be no reduction in service to a veteran.

6. **EXCHANGE OF DATA.**

Clinical or other medical records pertaining to the patients shall be exchanged.

7. **DISPUTES.**

a. In the event a dispute concerning a question of fact arises under this agreement, which cannot be resolved by mutual agreement between the respective Contracting Officers, the Cutler Army Hospital agrees to abide by the Contract Disputes Act of 1978 and Disputes Clause as follows:

(A) This agreement is subject to the Contract Disputes Act of 1978 (41 USC 601, Et. Seq.). If a dispute arises relating to the agreement, the Contractor may submit a claim to the Contracting Officer who shall issue a written decision on the dispute in the manner specified in DAR 1-3.4 (FPR 1-1.318).

(B) "Claim" means:

(1) A written request submitted to the Contracting Officer;

(2) For payment of money, adjustment of agreement terms, or other relief;

(3) Which is in dispute or remains unresolved after a reasonable time for its review and disposition by the Government; and

(4) For which a Contracting Officer's decision is demanded.

(C) In case of disputed requests or amendments to such requests for payment exceeding $50,000, or with any amendment causing the total request in dispute to exceed $50,000, the Contractor shall certify at the time of submission as a claim, as follows:

I certify that the claim is made in good faith, that the supporting data are accurate and complete to the best of my knowledge and belief; and that the amount requested accurately reflects the agreement adjustment for which the Contractor believes the Government is liable.
(Contractor's Name)
(Title)

(D) The Government shall pay the Contractor interest

(1) On the amount found due on claims submitted under this clause:

(2) At the rates fixed by the Secretary of the Treasury, under the Renegotiation Act, Public Law 92-41;

(3) From the date the Contracting Officer receives the claims, until the Government makes payment.

(E) The decision of the Contracting Officer shall be final and conclusive and not subject to review by any forum, tribunal, or Government agency unless an appeal or action is timely commenced within the times specified by the Contract Disputes Act of 1978.

(F) The Contractor shall proceed diligently with performance of this agreement, pending final resolution of any request for relief, claim, appeal, or action related to the agreement, and comply with any decision of the Contracting Officer.

8. EQUAL OPPORTUNITY.

Each party to this agreement agrees to furnish the resources specified in the appendixes hereto without regard to the race, color, religion, sex or national origin of the person for whom such resources are ordered.

9. OFFICIALS NOT TO BENEFIT.

No Member of or Delegate to Congress, or Resident Commissioner, shall be admitted to any share or part of this agreement, or to any benefit that may arise therefrom; but this provision shall not be construed to extend to this agreement if made with a corporation for its general benefit.

10. CONTINGENT FEE.

The Contracting Officers warrant that no person or selling agency has been employed or retained to solicit or secure this agreement upon an agreement or understanding for a commission, percentage, brokerage, or contingent fee, excepting bona fide employees or bona fide established commercial or selling agencies maintained by the parties for the purpose of acquiring business. For breach or violation of this warranty, the parties shall have the right to annul this agreement without liability, or, in its discretion, to deduct from the agreed price or consideration, or other wise recover the full amount of such commission, percentage, brokerage, or contingent fee.

11. NONAVAILABILITY OF RESOURCES.

In the event resources listed in the appendixes are not available at the VA, the VA will not be responsible for resources in any other manner.

12. TRANSPORTATION.

The Contractor will be responsible for transportation of the patient to and from the Boston Veterans Administration Medical Center. Additionally, an appropriate medical escort will be provided for the patient by the Contractor.

13. **PATIENT HISTORY.**

The Contractor is required to submit previous medical history on the patient to provide rational for the procedure to be performed.

14. **PRIVACY ACT.**

Attached.

15. **AUTHORITY.**

This agreement is entered into under the authority of 38 U.S.C. 5053 and is negotiated under the authority of FPR 1-3.204.

Approved and Accepted for Cutler Army Hospital, Fort Devens, Massachusetts, by:

____

____

(Title) **(Date)**

Approved and Accepted for Veterans Administration by:

____

____

(Title) **(Date)**

APPENDIX A

RESOURCES TO BE FURNISHED BY THE VA MEDICAL CENTER, BOSTON, MASSACHUSETTS

	RESOURCES	ESTIMATED QUANTITY	UNIT COST	TOTAL COST
SPECIALIZED OUTPATIENT SERVICES				(Per Month)
I.	Orthopedic Clinical Consultations	100 per month	$29 per exam	$2900.00
II.	Otolaryngological Clinical Consultation	12 per month	$29 per exam	348.00
III.	The following specialized services required in conjunction with Orthopedic/ Otolaryngology outpatient clinical consultations will be charged as follows:			
				(Per Annum)
	A) Radiotherapy Service (Supervoltage Treatment)	10 per year	$62.86 per treatment	$ 628.60
	B) ENG	24 per year	$25 per exam	600.00
	C) Bone Scan	24 per year	$35 per exam	840.00
	D) EMG	24 per year	$59 per exam	1416.00
	E) EMG with Nerve Conduction Studies	24 per year	$74 per exam	1777.00
	F) Arthrogram (knee)	50 per year	$79 per exam	3950.00
	G) Polytomogram (sinuses and facial bones)	12 per year	$51 per exam	612.00
	H) Polytomogram (temporal bone)	12 per year	$44 per exam	528.00
	I) Tomogram (larynx)	24 per year	$29 per exam	696.00
	J) Tomogram (bone)	36 per year	$40 per exam	1440.00
	K) Laryngogram	12 per year	$120 per exam	1440.00
	L) Sialogram	24 per year	$59 per exam	1416.00
				(Per Month)
	M) Specialized Orthopedic X-ray	100 per month	$15 per exam	1500.00
	N) Specialized Otolaryngological X-ray	12 per month	$20 per exam	240.00

APPENDIX B

RESOURCES	ESTIMATED QUANTITY	UNIT COST	TOTAL COST
SPECIALIZED INPATIENT SERVICES			
IV. Specialized Inpatient Orthopedic Services.	5 surgical procedures per month	$146 per day	*
V. Specialized Inpatient Orthopedic Surgical procedures:			
A)			
1. Reduction and Internal Fixation-Intertrochanteric Fracture Hip	**	$782 per procedure	**
2. Total Hip Arthroplasty	**	$1,568 "	**
3. Arthroscope of knee	**	$211 "	**
4. Bankhart Procedure	**	$694 "	**
5. Open Reduction-Fracture/ Metacarpal or Phalanges	**	$426 "	**
6. Repair Laceration Flexor Tendons-Forearm or Hand	**	$479 "	**
7. Ligament Reconstruction Knee	**	$554 "	**
8. Delayed Reconstruction Separated Acromio-clavicular Joint	**	$412 "	**
9. Debridement-Closed Reduction-Plaster Immobilation-Open Tibial Fracture	**	$631 "	**
10. Open Reduction-Bimalleolar Fracture of ankle	**	$418 "	**
11. Open Reduction-Both Bones of Forearm	**	$680 "	**
12. Open Reduction-Fractured Femur	**	$590 "	**
13. Close Reduction-Fracture Distal Radius (Colles Fracture)	**	$235 "	**

(From The Washington Post, Tuesday, July 29, 1980)

MILITARY, VA HOSPITALS FOUND NOT SHARING COSTS

By Victor Cohn

While the government preaches medical cost-saving, military and veterans hospitals often stand almost cheek-by-jowl without sharing the expert staffs and sophisticated equipment that cost billions.

The result, General Accounting Office officials have told Sen. Charles H. Percy (R-Ill.), is wasteful spending to the tune of at least "hundreds of millions."

A staff report to Percy—to be disclosed at a hearing before the Senate Governmental Affairs Committee Wednesday—gives these examples:

- The Navy spends $25 million a year at Great Lakes, Ill., to operate a partly empty hospital, with usually only 120 beds filled. At North Chicago, two-thirds of a mile away, the Veterans Administration plans to spend $25 million in coming years to renovate its aged hospital. VA patients cannot use the empty Navy beds.

- The VA has an ample supply of doctors at its North Chicago hospital, thanks to a medical school affiliation. With some exceptions, they cannot treat Navy patients, while a doctor shortage forces the Navy to spend $3 million a year for part-time private sector doctors and private sector care.

- For lack of a VA-Army agreement to share Boston VA orthopedic services, the Army flies "dozens of patients from Boston to Walter Reed Hospital in Washington on its very expensive air evacuation system."

- San Diego Naval Hospital eye patients cannot be treated with a nearby, often idle, VA laser. The Navy is planning a new $298 million San Diego hospital "without any coordination" with the nearby VA hospital.

Congress' General Accounting Office set out many more examples of lack of hospital sharing in a 1978 report, one of 16 it has made on the subject.

But the sharing between the two largest federal systems—the VA with 171 hospitals and the Defense Department with 129—remains "minuscule," according to the report to Percy by special assistant Alan Mertz.

In fiscal 1979, the VA had 20 sharing agreements with other health facilities, with $30.1 million in services being exchanged. But only four of the 240 agreements were with military hospitals, the report to Percy says.

The reasons why, says the report, include old legislation that prevents VA-military sharing in many cases; cumbersome regulations in other cases; official jealousies and, among the most serious obstacles, a huge financial disincentive.

If a hospital administrator agrees to provide a costly service, the money goes to Washington, not the providing hospital.

Percy has introduced a bill to eliminate many of these obstacles. He said yesterday he has received "enthusiastic support" from many federal hospital administrators and expects support on Wednesday from several military and VA medical officials.

(From U.S. Medicine--Sharing Report)

LEGISLATION PENDING TO MANDATE CROSS-AGENCY USE OF EQUIPMENT

By Terry L. Jemison and Suzanne Viau

WASHINGTON—Legislation is pending in the Senate that for the first time would require federal agencies to share medical equipment and facilities.

The bill, S 2613, was introduced by Sen. Charles H. Percy (R., Ill.) as a measure to promote efficiency in federal health care and to save money.

But whether there will be time for the proposal to be passed by Congress this year remains in question. Sen. Percy on July 29 and 30 will chair hearings on the bill as its sponsor and as ranking minority member of the Governmental Affairs Committee.

The bill is part of a package of measures Sen. Percy has introduced to attack "wasteful government spending," according to Alan Mertz, of the committee's minority staff.

"We've gotten a lot of constructive comments, and because it's non-controversial, I hope we could iron these out rather quickly," Mertz said.

The bill addresses barriers to sharing among government hospitals that were outlined in a 1978 General Accounting Office report.

Specifically, Sen. Percy observed in introducing his bill, "There are several laws that allow sharing, but none of them requires it. And while the agencies have made some progress, all parties agree that there is a need for legislative action."

Sen. Percy said his bill "is not designed to dictate sharing arrangements to the agencies providing direct health care." Instead, it provides a "legislative mandate for removing the obstacles to sharing and directs the agencies to implement sharing arrangements which they design."

The affected agencies—HHS, Veterans Administration and Defense Department—generally support the bill, Mertz related.

In fact, Sen. Percy's bill has preempted legislation being drafted by the Federal Health Resources Sharing Committee, established in 1978 to enhance sharing arrangements but partly stymied in its work by the lack of a mandate and other legal barriers to sharing, such as inequitable reimbursement arrangements.

Mertz said he could not explain why no other member of Congress has seized upon the 1978 GAO recommendations, especially since Congress increasingly has become concerned with balancing the federal budget and containing health care costs.

Sen. Percy pointed to these situations as examples of the kinds of inefficiency his bill, the "Federal Interagency Medical Resources Sharing and Coordination Act of 1980," is designed to counter.

- The Great Lakes Naval Base hospital operates with about 500 empty beds. Across the street is a VA facility which has planned $20 million worth of renovation.

"They could easily share the space," Mertz commented.

- In 1978, GAO found $21 million worth of CT scanner equipment was being proposed for purchase without a coordinated federal approach to planning and use.
- GAO also found that federal agencies were planning to modernize or establish new cancer treatment capabilities costing $16 million without coordinating the 23 locations where radiation therapy could be provided more efficiently through interagency sharing.
- Local Air Force and VA officials in Tampa had agreed to a plan to share radiology services at an annual savings of $120,000. VA central office rejected the arrangement.

The first chairman of the Federal

Health Resources Sharing Committee (FHRSC), Dr. Edward J. Hinman, said however there are problems not addressed in the Percy bill which should not be overlooked—geographic availability and accessibility of medical services shared, quality of care and patient satisfaction under sharing agreements, and the impact of resource sharing on recruitment and retention of medical personnel.

Dr. Hinman, now director of the Group Health Association in Washington, said Congress should take a look at these issues as well.

A VA member of an FHRSC subcommittee who has worked with sharing contracts for years, Alexander I. Kutner of the professional services staff, said although he can't speak for VA he personally feels the Percy bill would rectify many of the current disincentives to interagency sharing by allowing reimbursements to return to the hospital which provided the service (they now go to the general treasury) and allowing negotiation of costs.

However, he said he would like to see some changes in the bill.

VA, he said, finds the current situation to present a dilemma when it comes to calculating costs.

The Defense Department, he said, is limited in the amounts it can pay other agencies for shared services. By law DoD can pay no more than a general daily rate set by the Office of Management and Budget for inpatient and outpatient visits.

Because of these OMB-set limits, Kutner said, there is little incentive to share with the military—where the lion's share of savings could be realized—because DoD cannot repay in amounts high enough to cover expenses.

"If you take something like a CT scan which might cost the VA over $200 to do, the VA can only charge $50 (to military hospitals)," Kutner related.

"We're in a bind. We're in a Mexican standoff," he said.

Public Health Service hospitals, in contrast, have authority to pay "reasonable costs," he said.

SECRETARY OF HEALTH AND HUMAN SERVICES,
Washington, D.C., September 10, 1980.

Hon. ABRAHAM A. RIBICOFF,
Chairman, Committee on Governmental Affairs, U.S. Senate, Washington, D.C.

DEAR MR. CHAIRMAN: This is in response to your request for a report on S. 2958, a bill "To ensure the development and implementation of policies and procedures to encourage the Veterans' Administration and the Department of Defense to cooperate in the efficient and effective use of Federal medical resources, and for other purposes".

In summary, we support the bill, but recommend that it be amended to include the Department of Health and Human Services.

The bill would establish a Federal Interagency Health Resources Committee composed of the Secretary of Defense and the Administrator of Veterans' Affairs. The Committee would establish policies applicable to the Department of Defense and the Veterans' Administration regarding interagency sharing of medical resources. In particular, the Committee would prescribe guidelines which would require that facility directors enter into sharing agreements whenever possible, with the services shared not limited to specialized services; that the resources to be shared be negotiated by facility directors on a "negotiated cost" reimbursement basis with the reimbursement allocated to the particular facility which provided the service; that sharing agreements be on a referral basis, and not adversely affect a providing agency's primary beneficiaries; and that sharing agreements negotiated by facility directors be operative unless disapproved by an agency's headquarters. The bill also contains requirements for annual reports to various committees of the Congress on interagency sharing activities.

The Department of Health and Human Services (HHS) administers two hospital systems: the Indian Health Service, consisting of 48 hospitals, 101 health centers, and over 300 smaller health stations and satellite clinics; and the Public Health Service system, consisting of 8 hospitals and 27 clinics. While both systems engage in the sharing of resources with other Federal agencies, the Public Health Service system—because of the geographic location of its facilities—is especially active in this regard. For example, during Fiscal Year 1979, the Public Health Service system provided 9,162 inpatient days and 671,862 outpatient visits to beneficiaries of the Department of Defense.

We support the intent of the bill to continue and to expand sharing arrangements among Federal providers of medical services. We recommend, however, that the bill be amended to include the Secretary of this Department as a member of the Federal Interagency Health Resources Committee and to provide that the policies and guidelines established by the Committee be applicable to this Department. With this amendment, we recommend that the bill be favorably considered, but we defer to other agencies concerned as to specific issues of importance to them.

We are advised by the Office of Management and Budget that there is no objection to the presentation of this report from the standpoint of the Administration's program.

Sincerely yours,

PATRICIA ROBERTS HARRIS.